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Original Communications.

Infectious Gastro-Duodenitis, Catarrhal Icterus, or Weil's Disease.*

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HISTOLOGY OF DISEASE.

The first cases were published by Weiss, Chauffard and Landouzy in France, and Weil in Germany, during 1881. The disease has been called Weil's disease from the latter writer. While the writer believes in the disease as a separate, distinct disease; he also believes that Botkin, Hennig, Barthez, Kissel and others are right when they say, "All forms of jaundice not dependent upon mechanical obstruction are infectious." Koplik says, "The theory of the infectious nature of even the mildest cases of jaundice is supported by the fact that these cases occur in groups and epidemics." Wilson says, "Clinicians are not in accord as to whether the disease is a separate nosological entity." McPhedran says (Sajous' Annual), "518 cases reported in Saxony in 1889, 73 per cent of children in infected region attacked. Influenza predisposed to the disease." Many epidemics have been reported since. Hirsch alone collected reports of 34 epidemics. It is a little singular that hereto-

*Read before the Shelby County Medical Society.

fore no epidemics have been reported in Alabama, according to the best evidence we have at hand, though the disease has occurred in the State at more than one point, several times.

CONTAGIOUSNESS.

Warthin says: "Infectious jaundice is not contagious, but sometimes occurs in epidemic form. One attack seems to confer immunity."

AETIOLOGY.

Hennig says, "It is miasmatic." Parmentin charged it to marshy regions. Warthin says, "The cause is not yet known; the mosquito is supposed to be concerned in its transmission." Wilson and most authors now accept Jaeger's discovery of the proteus fluorescens as the sole aetiologic factor.

PATHOLOGY.

Koplik says, "In fatal cases, atrophy and fatty degeneration of the liver cells are found. The interstitial tissue around the portal vein is infiltrated with small round cells. There is parenchymatous degeneration of the kidney. Mild cases have not been studied."

DIFFERENTIAL DIAGNOSIS.

"The size of the liver will differentiate it from acute yellow atrophy; the absence of parasites in the blood from malaria."—Warthin.

SYMPTOMATOLOGY.

Wilson says, "Headache, vertigo, pain in back and limbs, great lassitude, temperature rises rapidly to 104° F, and assumes remittent type. The clinical picture suggests the severer forms of catarrhal jaundice, and various febrile forms of gastro-intestinal disease. Urine, albuminous, with hyaline and epithelial casts. Haematuria not uncommon." My cases all had low or sub-normal temperatures, no chills, slow or fast pulse according to age, severity of gastric symptoms and general depression; putty stools, highly colored and slightly albuminous urine, with in two or three cases a few hyaline and epithelial casts. No search was made for the proteus. In all cases there was extreme lassitude, jaundice appearing on the second and third day and continuing for from ten days to two weeks.

RECURRENCE.

McPhedran says, "It recurs in about one-fourth of the cases." I had no recurrences.

SEX.

McPhedran says, "It occurs in males from 15-30, but has been seen in children as young as eight. Wilson says, "Males are oftener affected than females. It is uncommon in children and after 50; most frequent from 25-40." Koplik says: "The disease is most common from the second to the fifth year."

TREATMENT.

The treatment is altogether symptomatic.

DISCUSSION.

It has been the writer's privilege to witness two epidemics of infectious gastro-duodenitis; the first, before he began the study of medicine, and the second during the months of November and December, 1906. The first epidemic was confined almost exclusively to adults; the latter to children. Most of the cases during the first epidemic occurred between the 20th and 50th year, men suffered more than women; the negro was practically immune. The epidemic occurred in the fall. Mosquitoes of the anopheles and stegomia varieties were to be found in the community, but as the date antedated the mosquito discoveries, no importance was attached to this phase of the question. There were 50 or more cases in the town at the time, many of them walking about the streets. While much local discussion prevailed among the doctors concerning the origin and nature of the malady, no one ever published any views on the subject. There was only one death, a young lady about grown, one of the earlier cases. In this case a diagnosis of yellow fever was made, which undoubtedly contributed no little towards the ultimate disastrous results. During Nov. and Dec. of last year, there prevailed in the town of Montevallo, an epidemic, rather epidemics, of scarlet fever, mumps, whooping cough, influenza, and a few cases of roseola. I mention this because of the well known fact that jaundice frequently occurs as a sequela, or is concomitant with these diseases. Just what germ, or germs, produced jaundice in the cases

about to be narrated, it is impossible to say for no attempts were made by microscopy to determine this point—only one of my cases had any other disease but the gastro-duodenitis. At first, my opinion was that each of my jaundice cases had possibly received infection from the scarlatina cases, which for some peculiar reason, manifested itself only in an icterus. One case alone, however, on account of its location led me to the present conclusion that the malady was a distinct entity.

CASES.

Nov. 1st, when two cases of scarlatina were under my care, I was called to see a five year old white child. This case was across the street, and 1-2 block up from two cases of scarlatina in the practice of a confrere. Nov. 5th, a three year old brother of this little girl developed an icterus similar in all respects to the little girl's. Just preceding this case, I learned that a confrere had two cases of icterus in the same family—a boy and a girl—a block and one-half behind my cases. Nov. 8th, I had my third case—a girl about eight. This case was only a block from the two other cases, and just beyond the home of one of our local doctors, who subsequently had his two little girls, about five and seven, to develop scarlatina. My next case, Nov. 11th, was a young lady, pupil of the Alabama Girl's Industrial School, about seventeen years old. She was boarding in town. This was the only case that occurred among the college girls. My fifth case was a negro woman, about forty, living a block from where the college girl boarded; her son, about grown, developed the disease about a week later. These two cases were the only cases among the negroes in the town, and in them, the disease pursued the clinical course of infectious gastro-duodenitis as laid down by Wilson. My seventh case was a little girl, seven years of age, who was convalescent only about a week from a severe attack of scarlatina, with septic complications. This was the only case in which there were many hyaline and epithelial casts, though with two others there was a slight transient albuminuria and a few casts. There was complete recovery in all of the cases, so that it was impossible to note any pathological changes, with the exception of those already mentioned and the fact that in all the cases there was more or less liver enlargement. In every case, the symptoms were in the beginning those of an

acute gastritis. None of the children had more than a degree or two of fever at any time. Most of them had a slight sub-normal temperature. In most cases the pulse was fast, rather than slow. The jaundice lasted in every case from a week to two weeks. Jaundice appeared a day or two after the acute gastric symptoms. The trouble subsided as suddenly as it began.

Hepatic Syphilis.*

By J. F. Jenkins, M. D.,

Piper, Ala.

This subject was selected because of an interesting case in my own practice, because a review of literature upon the subject indicates that it occurs more often than one would suspect, because of the obscurity of its symptomatology many cases go unrecognized, and finally because of all the abdominal viscera the liver is most often affected. In the secondary stage of syphilis, along with the skin irruption, fever and lymphatic enlargement there occurs an enlargement of the liver due to hyperemia which is transient in character and is only distinguishable from hyperemias from other causes by its ready response to treatment of mercury.

This hyperemia may produce symptoms of weight and discomfort in right hypochondrium and occasionally jaundice. But whether treatment is instituted or not, it is transient and rarely noticed or recognized. Clinically two types of liver syphilis are found, a diffuse and a circumscribed hepatitis.

The pathology of the first type begins primarily around the blood vessels and is a diffuse round cell infiltration in the interlobular spaces, which with increased vascularity produces enlargement of the liver. This cellular infiltrate later undergoes conversion into connective tissue when with consequent contraction the liver becomes less in size than normal, or it may undergo amyloid degeneration when the liver remains large and smooth.

The pathology of the second type or circumscribed hepatitis is that

*Read before Bibb County Medical Society.

of a gummatous deposit, consisting hystologically of a central cheesy mass surrounded by newly formed cells and fibrous tissue. These gummata vary in size from a pea to a hen's egg, and may be grouped or disseminated, and may involve a whole lobe or a part of a lobe or the liver. They are usually situated about the falciform ligament or along the portal vein. Finally they either soften and are absorbed or undergo fibrous contractions, leaving a very irregular surface to the liver.

In hereditary syphilitic hepatitis is found the diffuse type, producing the enlarged liver characteristic of these cases with their aged faces, snuffles, and latter Hutchinson's teeth. It usually develops within the first six months of infant life and its response to mercury is wonderful. In hepatic syphilis as a tertiary manifestation are found both the diffuse and gummatous types. It is insidious in its development and may remind its host of his youthful wars of venus forty years after the initial leison.

The first symptoms are usually referred to the stomach—as vomiting and eructations several hours after eating, heaviness or uneasiness in the epigastrium with the physical signs of enlarged liver or of a tumor in the epigastrium. This is the first stage and there is no interference with the functions of the liver or with the portal circulation. Then it is a readily curable condition. But as the disease progresses with contraction and formation of cicatrices, the arteries become hardened, the left ventricle enlarges, the second heart sound becomes accentuated, ascites develops with catgut madusa about the umbilicus, and perhaps jaundice. Emaciation is gradual. The liver becomes small and nodular and we have all the symptomatology of cirrhosis of the liver. Or the liver may remain enlarged and smooth with amyloid degeneration, when the kidneys and spleen are also effected and when the general symptoms presented are a muddy cachexia and diarrhoea. Then in either ultimate condition a curable disease becomes changed into an incurable.

A diagnosis of hepatic syphilis may be made on (a) specific history, (b) the alterations in size and shape of liver with symptoms milder than are attendant on such alteration from other causes, (c) digestive troubles, (d) a mild serous effusion rapidly recurring on evacuation, and (e) the therapeutic test.

Gumma of liver may simulate cancer, but cancer usually occurs after forty years of age, while the gumma at any age. The cachexia of cancer is rapid and fatal, while that of syphilis requires years to develop and may never prove fatal.

Prognosis depends on the stage of disease at which treatment is instituted, if before contraction and cicatrization or amyloid degeneration has taken place, it is wonderfully responsive to treatment; later it is incurable.

TREATMENT.

Dr. Witherspoon of Nashville thinks that mercury by mouth as in the form of bichlorid and in the skin by inunction the sheet anchor. And for hereditary hepatitis mercury is perhaps all that is necessary. But for the tertiary hepatitis most authorities recommend potassium iodid in large doses, and if the case is rebellious mercury by inunction until the physiologic effect is gotten.

In the case in my own practice I used potassium iodid in lx gr. doses t. i. d. One writer aptly says, "Happy is the man with an abdominal tumor if he has had syphilis, and thrice happy is he if his doctor institutes proper treatment before resorting to the knife."

My case, Sept. 15, 1904, Joe Brown, native of Madagascar, age 30, in bad health sometimes, complains of pain in epigastrium and shortness of breath. Examination showed tem. 103°, pulse 120 and a large nodular mass in epigastrium. Diagnosis tumor of stomach, probably cancer, sent him to St. Vincent hospital. Sept. 20, operation showed large tumor of left lobe of liver. Right lobe normal. Spleen and kidney and stomach seemed normal. Abdomen closed without interference. Oct. 10 came back to me with note from hospital physician that a history of syphilis had been elicited. Treatment was begun potassium iodid gr. lx t. i. d. Nov. 30 patient says he is well and has gone to work. No tumor can be felt in epigastrium.

Quinche reports following:

Case 1. Gummatous enduration in head of pancreas and cystic ducts that could be palpated, with typical attacks of gall stone colic. Operation disclosed that there were no gall stones, but a tumor which was not disturbed—it subsided under pot. iodid treatment.

Case 2. Portal veins and biliary passages compressed by a gummatous proliferation.

Cumstone reports following:

Case 1. Muscular man, age 45, complained of severe pain in region of gall bladder and was slightly jaundiced for several months. A nodular mass in region of gall bladder and liver enlarged. Diagnosis, tumor of liver and abdomen opened and a mass of adhesions surrounding gall bladder was found, but gall bladder normal. Abdomen closed without further interference. A physician present gave the information that patient had had syphilis formerly. On antisypilic treatment pain was relieved, tumor absorbed and patient recovered.

Case 2. Married woman, age 39, complained of pain in right hypochondria region and nausea; in early married life had had three discharges, but latter had given birth to two apparently healthy children. At examination patient jaundiced, tongue furred, no enlarged lymphatic glands, but a nodular mass in epigastrium. Operation disclosed tumor of left lobe of liver, which was studded with numerous smaller ones. A superficial one was excised and proved microscopically to be a typical gumma. Patient was put on inunctions of mercury and potassium iodid, 4 grammes daily. Recovery was rapid.

Case 3. Man, age 45, syphilitic history denied, had lost weight and become enemic, complained of hindrance to respiration, nausea and eructation of gas after eating. Percussion showed liver dullness three finger breadth below costal border and in epigastrium dullness to within three fingers of umbilicus and ill defined nodular mass was found in this space. A malignant tumor was diagnosed and operation performed. A pedunculated tumor from the under surface of liver was removed which proved microscopically to be a gumma.

The Treatment of Pelvic Inflammation in the Female.*

By W. P. McAdory, M. D.,

Birmingham, Ala.

Mr. President and Gentlemen of the Medical Association of the State of Alabama:

I feel a hesitancy in attempting to read a paper upon the treatment

*Read before the Medical Association of the State of Alabama.

of pelvic inflammation in the female—because all recent writers seem of the opinion that there is no such disease—but take each structure of the pelvis and describe its inflammatory diseases separately;—as, inflammation of the vagina, uterus, tubes, ovaries, etc.

Practically all patients who have chronic endometritis, pus tubes, abscess of the ovary, pelvic abscess, or troublesome peritoneal adhesions, at some time when we had the infection gaining entrance, suffered from an acute attack, when it was a matter of impossibility to determine whether she had one or all of the above organs inflamed. All of you who have watched these cases know that a diagnosis as to which organ is involved is impossible. In fact in these acute attacks all of the structures of the pelvis are more or less involved. These cases usually present the following clinical picture: chill, fever, rapid pulse, back-ache, pelvic pain, vesical and rectal tenesmus, extreme nervousness, vomiting and general malaise. Upon examination the abdominal muscles are found rigid in the hypogastric and inguinal regions with marked tenderness on pressure. Bi-manual examination after the first two or three days reveals a uterus fixed and tender.

This is a brief clinical picture with which you are all familiar, and it is to this class of cases that I apply the term pelvic inflammation. I know of no other that will fit so well.

Almost 99 per cent. of the cases of acute pelvic inflammation are due to either infection introduced into the genital tract during child birth or abortion; or to infection with gonorrhoea. In the case of the latter the infection usually follows the mucous membrane of the uterus into the fallopian tubes giving rise to acute gonorrheal endometritis and salpingitis in which not only the mucous membrane but the entire thickness of the uterus and tubes, with their peritoneal covering becomes inflamed, giving rise to a more or less general pelvic inflammation. In those cases where the infection is introduced in labor or abortion, the focus is usually found in the endometrium primarily, but may be secondary to an infection of abraded vagina or torn cervix. This infection may spread through the mucous membrane to the tubes and ovaries, or it may gain access to the pelvic lymphatics or veins, and spread in that way. It usually travels very rapidly so that all of the structures are soon involved.

The most favorable result of this pelvic inflammation is its resolution with the absorption of the inflammatory products, with practically no crippling of the organs involved, or we may have a chronic endometritis, pus tubes, ovaritis, pelvic abscess, etc. So in treating this condition, we shall first take up the means of preventing it, then how to handle the condition to bring about the best results.

In pelvic inflammation due to gonorrhoea, as a rule we have both fallopian tubes left in a crippled condition, if not full of pus.

In the treatment of the inflammation it is first important to determine the character of the infection. This can only be done with the aid of the microscope. Cases due to the streptococcus infection are hard to do anything for, in fact general supporting measures have given best results in my hands. Some advise the vaginal puncture, but I cannot say from experience how much good it will do.

The most important means of preventing the condition which we can control consists in surgical cleanliness in obstetrical work. When we realize that the vast majority of the cases that come to the Gynecologist are the result of the infection in child birth or abortions, I think it well to emphasize this, even if it is a much discussed subject, I think it should be rehashed and its importance dwelt upon wherever there is a gathering of practicing physicians.

Another method of preventing pelvic inflammation is as follows: If after labor there is evidence of beginning infection, there should be a careful examination made for infected abrasions of the vagina or cervix, and if such infected areas are found they should be thoroughly disinfected, these are often overlooked, because we are so sure that the trouble is with the endometrium. After this is done then examine for evidences of infection in the uterus, and if such is found, carefully swab out the uterus with gauze, then with carbolic acid or tincture of iodine, then pass a strip of gauze into the cervix and allow to remain for drainage; this should be accomplished very gently so as to prevent further infection as well as to conserve the barriers that nature has already thrown out. If this drainage is thorough, and the infection not streptococcus we will seldom have a case of pelvic inflammation to follow.

When the inflammation has become general the treatment that has given best results in my hands is as follows: rest in bed, thorough

cleansing of the bowels at the beginning of the attack by a dose of calomel followed by salts, and afterwards keeping the bowels open with mild salines and rectal irrigation, liquid diet with mild stimulation with strychnine and alcohol. Ice cap or coil to the lower abdomen has given good results in the relief of pain and aiding in the control of the temperature; if the ice causes an increase in the pain, as it sometimes will, apply heat. I do not believe it makes much difference which you use. If the pain is severe, there is usually a great deal of nervousness, and I try some preparation of bromides before giving an opiate. All writers advise against the use of opium as it masks the symptoms, but if the patient is suffering I use it.

Now for the local treatment. If the cervix can be dilated easily I do not use an anesthetic. As the mucous membrane of the uterus is most frequently the place where the trouble comes from, and for the purpose of drainage I adopt the following: Swab out the uterus with gauze, then with carbolic acid, then if the cervix is so that it will drain the uterus, I put the patient to bed and use hot vaginal douches twice a day. But usually the body of the uterus falls in such a position that there is a valve formed at the internal os, so that the uterus will not drain, so I place in a strip of gauze for that purpose. This is allowed to remain for thirty-six hours when it is removed and if necessary a fresh strip is inserted, which I allow to remain for thirty-six hours longer, when it is removed. Usually this is long enough to allow the gauze to remain, and it can be left out, using the hot douch of saline twice a day. I am not in favor of curetting a uterus with acute infection.

In those cases that do not terminate in suppuration, in about twenty-four hours the symptoms begin to subside and in a few days the uterus is found to be movable, and the induration disappearing with agglutinated masses on each side of the uterus. In this stage ichthyol and glycerine tampons sometimes help out, but great care must be used in placing them so as not to interfere with the drainage.

The cases which go on to suppuration with localized collections of pus are more serious, but in their beginning require the same treatment as the simpler cases.

Symposium on Scarlet Fever.*

Scarlet Fever—Clinical Types.

E. H. Sholl, M. D.,

Birmingham, Ala.

It is extremely difficult in the discussion of a disease of this kind to draw the line sharply and exactly in the investigation of these cases, as to treat it so that one shall not trend upon the other.

The portion assigned to me, symptomatology of the disease, clinical features. My first experience, gentlemen, with this disease was in the year 1858 and '59. I passed at that time of my first experience, through an epidemic of six or more months, of 79 cases.

The period of incubation, as has been stated, varies. The nature of the disease manifests itself by a chill invariably, lighter or more severe, according to the gravity of the case. Following the chill, within a few hours, there comes an eruption, which begins to show upon the chest, and within 24 hours, where the disease has its regular course, spreads over the entire body. We may be prepared to recognize scarlet fever almost invariably by the quick and rapid pulse, ranging from 140 to 160, and by the high temperature. In old days, when we had not the use of the thermometer, we came to a conclusion in reference to the nature of the disease by the rapid pulse and the quick appearance of the sore throat. We have in connection with the ruddy appearance of the throat the appearance of the tongue, so that it is now known as the strawberry tongue.

The most distinct manifestation that we have is the general condition of the skin. Red at first, deepening into a scarlet hue, and breaking out, at the end of from four to six days. As an illustration, however, of the protraction of cases, I am prompted to mention the case of two sisters. In one, the symptoms of scarlet fever, made their appearance, and passed through with return at the normal time of health. Soon after, a sister in the family was taken with sore throat and rapid pulse, and the temperature ran from 104 to 106,—with a pulse ranging about

*Read before the Jefferson County Medical Society.

160. This was a girl about nine years old, no deposit whatever on the throat, but with constant high temperature. She was enveloped in ice water, and kept in sheets until the 13th day. On the 13th day the eruption came out, well defined, and within 24 hours the temperature dropped down to 99, and soon dropped down to normal. We have in connection with this sore throat, an occasional deposit follicular in its character. Sometimes we have also a diphtheritic appearance of the throat, which is not the true diphtheria; it is not the particular bacillus, but we do occasionally have in connection with this scarlet fever deposit the true diphtheritic bacillus.

Another point that we have oftentimes in connection with it is rheumatism in the ankles, knees or the wrist. It has no immediate connection with the eruption of the disease, but manifests itself ordinarily from the 10th to the 12th or 14th day.

In those cases I saw in that epidemic, previously mentioned, I remember one case, in the negro, in old slavery times. The difficulty there in differentiating was solved (we had no thermometer in those days) by the condition of the tongue and the throat, a little elevation of the skin, but not sufficient to determine the real nature of the disease, without the rapid pulse and the sore throat. This one negro child, about six years old, had the customary trouble with her throat, which grew worse and worse, and in an effort at vomiting, the child choked and apparently was about to succumb to the trouble. I put my fingers down the throat, I had nothing else ready, and with the aid of the vomiting the membranous deposits in the trachea was discharged and the child's life was saved.

Another symptom we have after the active stage of the disease, is a dropsical condition, which is due to changes occurring in the structure of the kidney. In one case that I saw in town here, now a young man, then a boy five or six years of age; rapid and general swelling of the body took place, and he went into convulsions. By proper medication, which it is not necessary to allude to, the dropsy gave way within 48 hours, disappeared within 24 hours, he recovered consciousness, and is a young man now walking the street. Sometimes we have delirium in these cases of a violent character—then prolonged wakefulness.

Now, in reference to the contagion of the disease. It is not as directly contagious as measles, or perhaps, as mumps, but the operation of the contagion has one remarkable symptom connected with it. I

know of one house in this town on Fifth avenue, between Nineteenth and Twentieth, where there was a case of scarlet fever. The house was fumigated; the paper, however, was not taken off. A year from that time another patient was taken sick with scarlet fever in that same room, and went through the ordinary course and recovered.

In Philadelphia, some children, who had the scarlet fever, were playing with some books in their convalescence; those books were packed away, and the family moved to England. Twenty-six years afterward, in England, those same books were unpacked and were given to some children to play with and within a few days an epidemic of scarlet fever broke out. Twelve different physicians were called in, and they all decided that the contagion, as there was no scarlet fever near nor had been for a length of time, had been lying in those books for twenty-six years, showing as it is generally known, the virulence of the disease.

I think, gentlemen, I have covered briefly the ground allotted to me. I do not care to trespass on anything else, or any other part, and so I leave these symptoms. If there is anything else I have omitted, it just may have escaped me now, and may be taken up by someone else. I only know this much, that when we deal with it, we deal with a disease that is more readily recognized than almost any other disease, by the symptoms as have been presented tonight.

Question. What has been your experience as to the virulence of the infection, here in Birmingham?

Answer. I have known of cases in one family,—a violent case, and two other children exposed to it, and did not take it at all. I can report another case, three children in the family, where the contagion just spread from one to the other. I would say that in all my experience now, of fifty-one years dealing with scarlet fever, I have never yet seen a fatal case, of pure, uncomplicated scarlet fever. Its classified symptoms are regular, irregular and malignant. It may vary, and have different forms, in which it presents itself, but those are the classified conditions, in which it ordinarily obtains here in the city. I just gave those two cases as illustrations of the general tendency of the disease. We have it here in a much milder form, ordinarily, than it is in the North. There are some epidemics more virulent than

others, but in all cases I have seen, the symptoms have never been such as to expect a fatal termination. I have been fortunate in that respect; I do not claim anything for medical treatment, but more to the nature of the disease and the symptoms manifested.

Scarlet Fever: Differential Diagnosis.

*By J. H. Edmonson, M. D.,
Birmingham, Ala.*

For differentiation of the exanthemata, measles, rotheln, scarlatina, variola and varicella, duration, incubation and nature of invasion, bears almost as much importance as lesions—their location, distribution and arrangement.

Measles.—Incubation 8 to 15 days, but generally about 10 to 12. Invasion of 3 or 4 days presents prodromes which generally make it easy to predict the oncoming eruption. First, symptoms of cold appear with watery eyes, coryza and husky voice; on same day, eyes become injected and pus often found in inner angle—headache noticeable. On second day patient develops deep hoarse cough some pharyngitis and laryngitis which has a tendency to increase in severity as disease progresses. Koplik spots now appear. Muscular soreness especially of upper part of body is present. Patient has mild fever, gradually rising and on third or fourth day 103-104°, the face becomes swollen, red and little later same day lesions—red, lenticular, macular—appear on this region or on neck and chest. They are slightly elevated, disappear on pressure, later (within few hours) become papular, and are distributed over entire body and extremities, no tendency to symmetry; arrangement of some, grouped in crescentric formation, others formation of blotchy character. Lesions become mulberry red, have tendency to locate on face more than other parts; remain four or five days then begin to fade when a pityroid desquamation sets in lasting from 10 to 12 days, often longer.

Differentiation has to be made from rotheln, variola, scarlatina, dermatitis medicamentosa (balsams) macular syphilide and erythema multiform. Rotheln, incubation longer, shorter invasion, mild prodromes and multiple adenopathy. Temperature rarely above 100 to 101 F, no desquamation, lesions very irregularly arranged and much brighter color than in measles.

Variola.—Prodromes more severe. No catarrhal symptoms. High temperature from first day. Sudden drop to normal on appearance of rash. No regularity in arrangement of lesions. More shot like and lighter color, later become vesicular and pustular.

The mobiliform eruption is less elevated, irregularly arranged and distributed over axilla and groin.

Scarlatina.—Incubation and invasion shorter; strawberry tongue, sore throat and angina; no catarrhal symptoms, no Koplik spots; rash more erythematous, less regularly arranged and less tendency to effect face; first appears on neck and chest; desquamation more profuse.

Dermatitis medicamentosa—(balsams)—no incubation, no catarrhal symptoms; lesions occur thickest on wrist, knees and around hair follicles; more different lesions; pomphi, vesules, bullae and petichiae sometimes appearing; pruritus generally very perceptible; odor of drug on breath, and most always urethritis present.

Maculae syphilide.—History: Absence of catarrhal symptoms; sluggish character of lesion, first purple, then yellow, red, pimply, brownish yellow; face generally free.

Erythema multiforme.—No prodromes; location, wrist, back of hands and neck, bilaterally and symmetrically distributed and irregularly arranged; multiforme lesions.

Rotheln.—Griffith says: "The disease may be divided into two types, resembling mild measles then mild scarlet fever and then all gradations; incubation 14 to 21 days; invasion few hours; slight catarrhal symptoms—temperature begins from first 100 to 101; never gets much higher; eruption develops in few hours, generally remains about 24 hours, then begins fading on face; multiple adenopathy of glands of neck and axilla very perceptible; lesions begin on face as light red macules, at times size of split pea, more or less grouped, then again confluent in patch or universally, not elevated, uniform redness, spreads rapidly over body, generally considerable pruritus; no desquamation; spots of brownish hue may remain week after lesions.

Diseases to be differentiated.—Measles (already mentioned); scarlatina, influenza, erythema multiforme, dermatitis medicamentosa.

Scarlet fever.—Incubation shorter; prodromes and higher temperature, strawberry tongue; lesions appear first on neck and shoulders; more erythematous; marked desquamation.

Influenza.—Shorter incubation, no prodromes, generally no eruption,

but when present may develop on any part of body, as erythema and urticaria, local or general.

Erythema multiforme.—No incubation nor prodromes, eruption localized to hands, wrists and back of neck (generally); lesions larger and greater variety.

Dermatitis medicamentosa.—Same as measles.

Scarlatina.—Incubation 8 to 15 days; sudden onset, generally with chill; children often have convulsions; temperature 104-105 first day; pulse very rapid (130 to 150); marked dysphagia due to angina; tongue red on edges, furred in centre through which enlarged red papillae are observed. Eruption appears on first or second day in folds around neck and chest—head being little affected—as scarlet red erythema, finely punctated with violet red points, more or less prurigenous, spread over body in next two days; about third day the tongue desquamates from tip forming characteristic strawberry appearance; eruption remains five or six days and begins fading, temperature gradually falling as it fades; about eighth to tenth day desquamation begins in folds of flexion, first as floury powder in hairy regions, scales where skin is thick and flaked on thicker parts, as hands and feet; terminates in thirty or forty days.

To be differentiated from measles: rotheln (already mentioned); diphtheria, acute exfoliating dermatitis, dermatitis medicamentosa, erythema scarlatiniforme.

Diphtheria.—Eruption limited to trunk, not as persistent; lesions darker; microscopical examination reveals Loeffler's bacilli.

Dermatitis exfoliativa.—Absence of high temperature and pulse rate; no strawberry tongue or throat symptoms; no punctate macules; a chronic condition with acute exacerbations; when desquamation sets in scales have tendency to adhere at upper end, lower end being free.

Dermatitis medicamentosa.—Following drugs produce erythematous eruption but have no prodromes: belladonna, chloral, quinine, iodide of potash, mercury, nux vomica, sulfonal. All generally have multiform lesions and much pruritus, and no regular location.

Erythema scarlatiniforme.—No prodromes, mild tendency, early desquamation, tendency to relapse.

Variola.—Incubation 8 to 15 days. Invasion very severe, chill, sometimes convulsions; two forms—discrete and confluent. Severity of prodromes is claimed by some to indicate which form will follow, but this is very doubtful. Temperature rises rapidly to 103 to 105 first or

second day; very intense headache and lumbar pains; skin dry; face flushed; usually on second day a rash appears of a scarlatinaform, mobiliform or purpuric nature in the axilla, on back of arms and abdomen, and vanishes with appearance of the papules; eruption proper appears on third or fourth day as small red spots, which in few hours become papular, elevated, indurated, and shotty to touch; first seen on mucous membrane of mouth, then on forehead and wrist, then spreading over whole body, appearing usually where there is greatest supply of blood. The temperature falls with appearance of eruption and premonitory symptoms disappear; usually about 5th or 6th day papules become vesicular, containing clear fluid, and umbilicate; eighth day pustules are formed from vesicles, become globular in shape and usually umbilication disappears; face is very edematous; fever and general symptoms recur, subsiding usually in three or four days, though sometimes lasting week or more; pustules begin drying on face. In confluent form symptoms are more severe, lesions coalescing on face, feet and hands mostly.

To be differentiated from measles.—Scarlatina (already mentioned), pustular syphilis, impetigo contagiosa, varicella, typhus fever.

Pustular syphilis.—History, lack of prodromes, lesions grouped, come out in successive crops, not so uniform in size, not often seen on palms and soles, more stubborn in character, usually papules with visicopustular tops rather than true vesicles and pustules.

Impetigo contagiosa.—Lesions limited mostly to exposed parts, no constitutional disturbance, lesions larger, more superficial and never papular.

Varicella.—Invasion less severe, eruption on first day, no secondary fever; lesions appear first on shoulder and chest generally; more superficial and irregularly formed; no papules; begin as vesicles, except on palms and soles. (Rare).

Typhus fever and cerebro-spinal meningitis eliminated by non appearance of characteristic lesions.

Varicella.—Incubation ten to twenty days; invasion mild; eruption first day; fever rises on appearance of eruption; lesions appear mostly on unexpected parts; begin as macules, few hours later become vesicular, then pustular, superficial, flat irregular shaped, collapse early; rarely found as papules (on palms and soles); lesions come out in successive crops; no scars; multinuclear epidermal cells found in secretion of vesicle or on floor. To be differentiated from variola—already mentioned.

Scarlet Fever: Complications and Treatment.

By W. C. Gewin, M. D.,

Birmingham, Ala.

A slight study on this subject reveals to us the fact that this disease is a most serious one as far as complications and after effects are concerned. In his study of the disease, Dr. Holt treats first of the complications arising in the throat—classifying them as: (1) erythematous angina, (2) membranous angina, (3) gangrenous angina. The first, however, can scarcely be considered a complication since it is as constant as scarlatinal rash.

Membranous angina, formerly classified as scarlatinal diphtheria, was for a long time the subject of much discussion as to whether this process was identical with primary diphtheria or not. It is now agreed, though, that membranous angina which appears early in scarlet fever and that which develops at the height of the disease, are almost invariably due to the *strepptococcus* (*diphtheria bacillus* being rarely present); but that the cases which develop late in the disease and after primary fever has subsided are nearly always true diphtheria—*bacillus* being regularly present.

3. Gangrenous angina—what its name implies—appears in the worst cases of scarlet fever and is sometimes insidious in its development. The termination is usually fatal.

Let us note now the effect of such conditions on the lymph nodes. They are swollen. The inflammation may be simply an acute hyperplasia or it may go on to suppuration. Disease of these glands is not an infrequent cause of *forticollis*.

Another severe result from gangrenous angina is *cullitis* of the neck. This usually occurs toward the end of the first week. There is rapid infiltration, the skin is tense and brown, the head is drawn back and breathing is difficult. Infiltration may be near lymphatic glands or it may be diffuse. Incision is the surest relief in diffuse infiltration, otherwise it might result in suppuration or sloughing. Other dangers would then naturally arise, namely, *septicaemia* (before or after sloughing), or hemorrhage from the external carotid this becoming ulcerated. Death, of course, must be the outcome of both,

B. Ears. Here we come to another serious complication accompanying scarlet fever. While it does not result fatally like gangrenous angina, it so frequently leaves the patient maimed for life. This ear affection known as Otitis is due to the direct extension of the infection from the rhino-pharynx and is a most frequent complication of S. F. Like all other complications, it varies greatly with the epidemic and is closely connected with the severity of the throat symptoms. The younger the child the greater his liability to otitis. As a rule both ears are affected, but not simultaneously. Rupture takes place at different times—most frequently during the second week. In some cases where otitis develops at the height of the disease there are no new symptoms; while in others there is pain and deafness. A rise of temperature follows the development of otitis at a later period.

C. Kidneys. Albuminuria accompanies nearly all the severe cases of S. F. In cases where there is severe throat complications, the inflammation of the kidney is described as exudative nephritis. As a result we may see dropsy in the different tissues.

D. Joints. Acute articular rheumatism may occur coincidently with the development of rash and occasionally during convalescence in patients with predisposition to this disease. The acute swelling of joints which sometimes occurs is due to pyaemic origin. The large joints are usually involved. The most characteristic form of inflammation along this line is scarlatinal synoritis, occasionally called scarlatinal rheumatism. This is seldom seen in children under three years and is most common after five years.

E. Lungs. Pulmonary complications are neither so frequent nor important as those of measles. In septic cases pleuro-pneumonia sometimes occurs early in the disease, sometimes late and is generally associated with nephritis. Empyema may follow pleuro-pneumonia or occur with pyemia and nephritis. Oedema occurs chiefly with nephritis and is most frequently cause of death.

F. In the sixth place, we consider the effect of S. F. upon the heart and learn that abnormal cardiac sounds, not dependent upon organic lesions, occur frequently during the height of the disease. Endo- and peri-carditis are not very common. They generally follow post scarla-

tinal nephritis. Endo-carditis may be simple or malignant and causes embolism or hemiplegia during convalescence.

A certain degree of degenerative change of the cardiac muscles is evident in every fatal case that lasts over four days. Toxic myo-carditis is not infrequent in prolonged and septic cases. It may be followed by acute dilatation of the ventricles.

G. In considering the effect of S. F. upon the digestive system we find that functional disturbances are evident in most cases, while organic changes are rare. Catarrhal stomatitis is a very frequent complication. H. The nervous system suffers less from complication and after effects than with most of the infective diseases of such severity. Meningitis may occur as a complication of otitis. Hemiplegia sometimes results from meningeal hemorrhage or from embolism, secondary to endo-carditis and associated with nephritis. Acute mania has been observed, but with complete recovery in a few weeks or months. Cor-rhea has been noted rarely. Besides its destructive and weakening effects upon various organs of the body, it has been known in many instances to bring about the patient's death in a most horrible way. I speak of what is termed symmetrical gangrene. While all parts of the body may be involved, the buttock and thighs are usually. The process generally begins simultaneously in several places, in rapid succession, and advances steadily until death occurs.

TREATMENT.

As with other eruptive fevers, so with S., there are no specific remedies by means of which it can be arrested or controlled. Symptomatic treatment judiciously applied, however, may afford relief and diminish fatality. Indications are for rest in bed, good ventilation, isolation, disinfection, cooling drinks, action upon skin and kidneys, and liquid nourishment.

For a case of mild scarlet fever, small doses of calomel, bicarbonate of soda and pulvis ippecac in the right proportion, and according to age of patient, every two or three hours until thorough movement from the bowels occurs, will favorably influence the fever, rapid pulse, and general distress.

For cases with high fever and for rapidity of the pulse use aconite, digitalis, or phenacetine in small doses every two or three hours with

cool sponging or cold bath. Repeat the baths if temperature and nervous phenomena are marked. If surface be pale, circulation feeble and eruption tardy in appearing benefit will follow the administration of tincture of digitalis (according to age) with hot broth or pack. With the appearance of eruption the entire body may be anointed with an ointment composed of eucalyptol, carbolic acid and lanoline in proper proportions. The inunction acts beneficially in many ways. It reduces the fever by soothing the cutaneous burning and irritation; later on, when desquamation occurs, it limits the source of further infection by preventing the diffusion of the otherwise dry scales in the air. It may also protect the surface from the effects of sudden change in temperature (of the air).

For scarlatinal angina, the internal use of iron in some form is valuable as a blood tonic and throat astringent. Externally, ice or cold compresses may be used unless they cause chilliness. In this case heat should be substituted. Astringent gargles and small pellets of ice dissolved in the mouth are of use.

The throat and nasal cavities are kept clean and the breathing relieved by the use of Dobells' solution applied with a hand atomizer every few hours. Another excellent mouth and throat cleanser, as well as gargle, is dioxide of hydrogen—full strength or diluted.

For malignant scarlatina, in addition to iron and quinine, the chief reliance must be on alcoholic stimulants—guiding the amount by their effects. With children, wine, whey, milk-punch and eggnog are eligible for the administration of stimulants and nourishment. In cases of convulsions which are generally due to high fevers, experience teaches us not to use the groupe—anti-perectic drugs—as they do not meet the conditions promptly enough. The cold, wet packs or cold bath with the ice cap are the most efficient and rapid means of reducing temperature and relieving the nervous disturbances. If diphtheria develops, full doses of anti-toxin should be given with free alcoholic stimulations as the case may demand.

A prudent practice is to examine the urine daily. If albumin should appear the patient may be benefited by a prescription composed of acetate of potash and sweet spirits of nitre given in proper proportions according to age. Follow this with saline purgation and a hot bath, or the hot air bath twice or oftener daily as the case may require. If ure-

mic convulsions occur use hot air bath, cupping over the kidneys, hyperdermic injections of pilo-carpine nitrate. The inhalation of chloroform, or may be the rectal use of choral hydrate with or without potassium bromide. Uraemic symptoms are sometimes controlled nicely by full doses of benzoate of soda. Elimination of the poison producing these convulsions is assisted by the high bowel enema of a normal salt solution.

For scarlatinal rheumatism the use of iron in conjunction with salicylates gives best results. Hot air treatment is also recommended.

For inflammation of the middle ear, it is better to puncture the drum membrane than to allow its ulceration. After puncture in sufflation by boric acid the internal use of ammonia is the best course to pursue.

For the various other complications the treatment plus some tonic is the same as if they occurred primarily.

Scarlet Fever: Disinfection and Prevention of the Exanthemata.

By R. B. Harkness, M. D.

Birmingham, Ala.

One of the chief drawbacks in handling the infectious diseases is the absence of absolute knowledge as to the etiology. This is especially true as regards to scarlet fever, without knowing the etiology of the disease more definitely we cannot take precautions in preventing the spread that would otherwise probably be taken. Another thing is, that the period during which the contagion lasts is also a mooted question. Some claim that these diseases are only contagious or infectious during their acute stages, others that the period of contagion ranges through the whole course of the disease, another thing that detracts from preventing the spread of these diseases is, cases that are overlooked. This perhaps is a very important factor in the spread of infectious diseases. Along the same line the occurrence of disease in a latent form is frequently responsible for its spread. For instance, it is a well known fact that the Klebs-Loeffler bacillus may be present in the throat of an apparently healthy person and while it has never been definitely proven that cases of diphtheria arise from instances of this kind, it certainly has not been disproven, so that every person carrying about with

them the bacillus of diphtheria should be looked upon with suspicion. It has been practically determined that persons apparently well have carried the contagion of scarlet fever. It is a well known fact that cases frequently occur after coming in contact with a person who has no other ailment than perhaps a mild angina. So we see, when dealing with the prevention of the spread of these diseases a good many unknown factors arise that cannot be handled intelligently. When you have your diagnosis clear the management then becomes comparatively simple. Of course the patient is to be isolated. In dealing with scarlet fever especially the fact should be borne in mind that you have a disease, the duration of which is several weeks at least and every precaution should be taken to make the patient as comfortable as possible. A large, well ventilated, sunshiny room should be chosen in which the invalid may be quarantined. This room, of course, should be as destitute of drapery, carpets, etc., as possible, and right here I want to say, that whether there is very much danger in it or not, one of the greatest things that creates anxiety among the neighbors is the hanging out of curtains, rugs, etc., to be aired and sunned from a house in which a scarlet fever patient is quarantined. We all know that sun light inhibits the growth of all pathogenic organisms and probably there is very little danger from these things, still it is a source of a great deal of uneasiness to the neighbors, and if these things are to be cleared from the room which is chosen to quarantine the patient in, they should be put away in some closet or room until the case is dismissed and fumigation is carried out. Of course, scarlet fever is the principal one of these diseases that we have to deal with, not only on account of the serious nature of the disease, but on account of the tenacity with which the organisms that produce it cling to life. While the germ that is responsible for scarlet fever has not been determined the consensus of opinion is rather in favor of some variety of streptococcus. Now of course in handling these diseases the excretions and secretions should be disinfected at once and where proper measures are carried out throughout the course of the disease, you have in my opinion very little use for disinfection, which is at best a comparatively uncertain procedure. The linen that is used by the patient, should be immediately immersed in water and boiled. You should not trust to antiseptic solution to render these innocuous, because we all know that

antiseptics are more or less uncertain. Small pieces of linen or of cotton that may be immediately burned should be used for cleaning the nose, pharynx and mouth. No toys or books should be allowed in the room except those that may be destroyed entirely.

There has been raised a point as to whether the attending physician endangers the public at large or not, owing to the possibility of his carrying the infection. Owing to the briefness of his visit usually, there is practically no danger in this unless he might carry the disease in a latent form.

It is well, however, for the physician to take the precaution of putting on a gown before going into a room in which is quarantined a scarlet fever are allowed the liberty of the house after the acute symptoms before leaving the house.

The nurse, however, who is in constant attendance upon the patient probably runs a greater risk of carrying the infection.

The child should be confined in an apartment that is set aside for its use entirely. It is frequently the case that children suffering from scarlet fever are allowed the liberty of the house after the acute symptoms have subsided, and in this way infection is more or less scattered through the house. During the eruptive period of scarlet fever carbolyzed vaseline may be applied over the entire body in one half to one per cent. strength. This not only gives great relief to the child in allaying the intense *itching*, but probably lessens the danger of spreading the contagion in the scales, more in a mechanical way, I should say than from any antiseptic effect you might get from the drugs incorporated in your ointment.

As to disinfection as I said a moment ago if proper precautionary measures are carried out during the course of the disease I think the disinfection is a matter of small moment. Some go so far as to say that it is absolutely unnecessary. I think it a precaution that certainly should be taken in all of the more serious infectious diseases. Perhaps the best agent to use in disinfecting a room is formaldehyde. As it is now used the process is very simple. Expensive apparatus that you formally used to generate the formaldehyde gas has been discarded to a great extent. We are now using permanganate of potash over which is poured the 40 per cent solution of formaldehyde. A chemical reaction takes place very quickly during which the formaldehyde is liberated.

The whole process only takes about five minutes, so you get your formaldehyde gas liberated into the room in a very short space of time, much more quickly than is possible with the expensive apparatus that was formally used. This process is especially applicable in rural districts where facilities are not to be had which exist in more thickly populated sections.

The United States government service has adopted this method of fumigation. The time of exposure as recommended by their experts is about two hours. In working here in the city, we use about fifteen ounces of the crystals of ordinary commercial permanganate of potash with about two pints of 40 per cent. solution of formaldehyde to the ordinary living room. Where the room is not closely built the openings should be cealed with cealing paper. The time of exposure we generally allow is about twelve hours.

THE APPROACHING CONQUEST OF CANCER.

Robert Bell refers to the recent work of Beard in relation to the trypsin treatment of cancer. He considers it of the first importance in the treatment of cancer to aim at restoring the functional activity of the thyroid gland and at the same time to adopt measures which will reduce the tendency to the introduction of toxic material from the intestines. This can be accomplished only by adapting the dietary to the requirements of the body, and to the capability of the digestive organs to completely digest and assimilate the food, aided by the thorough evacuation of the effete matter at least once in the twenty-four hours. The thyroid, however, is not the only organ whose utility is impaired. It is likely that the pancreatic secretion is to a certain extent in abeyance, and as a rule, the proportion of hydrochloric acid in the stomach is greatly diminished. The writer believes that cancer is the culminating point in a series of changes in certain important organs, consequent upon a vitiated blood supply which in turn is greatly due to gross negligence of hygienic laws and overindulgence in unsuitable articles of diet.—Medical Record, February 16, 1907.

Society Reports.

JEFFERSON COUNTY MEDICAL SOCIETY.

Regular meeting held March 11, 1907.

The President, Dr. Wyman, announced that we would have for this evening a Symposium on Exophthalmic Goiter as follows: Pathology, Dr. J. M. Lowrey; Etiology and Symptomatology, Dr. U. J. W. Peters; The Medical Treatment, Dr. J. D. Heacock; The Surgical Treatment, Dr. J. D. S. Davis. (The above papers were published in the April number of the Journal. We regret that this discussion was crowded out of that number.—Ed.)

After the reading of these papers the following discussion on them was had:

Dr. Torrance:—I have never had any personal experience with Goiter. I want to report a case that Carrell mentions in his experiments. Anastomosis was made between the Carotid Artery and the inferior thyroid vein in an animal with symetrical, parenchymotous goiter with pronounced general symptoms.

Two weeks later the thyroid had decreased on the side operated on, and seemed harder and more dense to the touch. Then general symptoms improved steadily as the gland decreased in size. Six and a half months after operation, the gland was markedly diminished in size on both sides, and became much firmer. The unoperated side was still larger than normal; all general symptoms had disappeared, and except for an enlargement of the gland, the animal was perfectly normal.

Microscopical examinations made from small sections of both glands showed the one operated upon to be much more normal in structure and containing far more colloidal material. He does not know whether the additional amount of blood brought to the gland had the effect on it, or whether it was due to section of the nerves in performing the operation.

He mentions this in his article in Surgery Gynecology in Obstetrics, in March, 1906. As to the statistics, Koker, in 1905, reports one thousand cases with a mortality of one per cent. I do not know how many of those were Exophthalmic Goiter. Later on, he reported seven

hundred, with the same mortality, in which eighteen were malignant, and fifteen were Exophthalmic. He still later has reported 1,100 with three deaths. Last June, he reported 176 cases Exophthalmic, with nine deaths, a mortality of about 5 per cent. In Mayo's 300 cases, he had 110 Exophthalmic, with nine deaths, which is about 8 per cent.

Dr. W. M. Jordan:—I have not been waiting for an invitation to discuss this subject, but have refrained from doing so because I had nothing in particular to say. While I am up, however, I will speak of one or two phases of the subject.

While there can be no question that in the present state of our knowledge of this disease the surgical treatment offers the best chance of cure, still the ultimate results are not as reliable as we could wish. I am inclined to agree with Dr. Riggs, that the field of internal medicine will ultimately reclaim this disease as its own. In this connection the recent researches in regard to "hormones" may have a bearing. It has been found that there are certain physiological stimulants, or hormones, which excite various glandular organs to increased activity. Now if a hormone should be found which would increase the activity of the suprarenal glands, bearing in mind the antagonism between the thyroid and suprarenal secretions in their effect on the circulation, it might be possible that the substance could be used therapeutically to counteract the circulatory symptoms of exophthalmic goiter.

Dr. H. S. Ward:—I am glad that Dr. Jordan brought up the subject of hormones. Many references are being made to them in recent literature. They are chemical messengers produced in one organ to stimulate the action of some distant part and are practically synonymous terms with internal secretion. The hormones of the thyroid stimulates the general metabolic functions of the body. The hormones of the suprarenal affect the sympathetic system. Mayo thinks the functions of these two glands when normal balance one another. It must be from some such idea that removal of cervical sympathetic ganglion improves exophthalmic goiter.

Young Cohnheim discovered the hormones of the pancreas which stimulate the glycosuric function of the muscles. Mayo speaks of others from the interior of the stomach which in conjunction with our sense of smell, taste, etc., tells us when our appetites are satisfied. It

may be that the foetus secretes hormones which stimulate the growth of the mammary glands of the mother, and the corpus luteum those which influence menstruation and the course of pregnancy.

One word or two about the pathology. It seems that in the simple goiter the acini of the gland are filled with a colloid substance, and this colloid substance increases in size, and that in turn presses upon the little cells, which line the acini, and thus by enlarging destroys these cells, and by that means destroys the function of the gland, while the true exophthalmic goiter shows a disappearance of this colloid substance, with an enlarging of these cells and increase in their number, folding in one upon the other thus increasing the functioning portion of the gland, giving the clinical symptoms of exophthalmic goiter, which can be produced by feeding upon the thyroid extract; in this way proving that the disease is due to a true hypertrophy of the parenchyma of the thyroid.

I would like for some of the "eye" men to explain the cause of the exophthalmos. This is a subject which has been very widely discussed, and I would be glad to hear the latest and most reasonable theory.

Dr. D. F. Talley:—I think it is all very nice to theorize on this subject and hope for what may come later on when we know more of the physiology and pathology of goiter, but this does not relieve nor satisfy the patient who is suffering with violent tachycardia, distressing dyspnoea excessive nervousness and malnutrition.

It is evidently a mistake to discourage surgical measures for the relief of this, as well as any other condition, until some other method is found which acts as well.

Some of the doctors here tonight who have spoken discouragingly or lightly of the advisability of a surgical procedure have gone off and left their patients without even the slightest suggestions as to what would benefit them.

Kocker, who has probably had by far the greatest experience of any man in operating on this condition said, at some recent congress of medicine in Europe, that the profession should cease to consider an operation as a last resort in the treatment of goiter, as many cases are allowed to go on until they are too weak to stand a surgical procedure; this same old battle has been fought with reference to appendicitis and many other surgical conditions in which the disposition to wait while

medical means are tried longer has caused many deaths. One very important item in the clinical pathology of goiter has not been mentioned, and that is the disordered metabolism which accompanies most cases and by this the patients nutrition is seriously impaired; this is especially true in the exophthalmic variety.

Dr. Chas. Mayo who has operated more than two hundred cases claims that one of the notable advances made recently in medicine in this country is in the surgical treatment of goiter.

My experience in the treatment of this condition has been limited and so far as I know it is not a common condition in this part of the country.

I have operated on two cases in the past five months; one a unilateral cystic goiter which was not large but had cause tachycardia and some dyspnoea and was interfering with the proper nutrition of the patient probably by causing a disordered metabolism.

In operating on this case ether anesthesia was employed and the diseased lobe removed, patient progressed nicely, although she had a run-away heart for several days following the operation; after three days the heart quieted down and she left the hospital for her home, some hundred miles away, in one week after operation. The last case on which I operated only a few weeks ago was of the exophthalmic variety, the gland was not very much enlarged but her left eye was considerably protruded and there was quite an unnatural stare in the right eye; she was extremely nervous, suffered with dysnoea, tachycardia and malnutrition. Ether anesthesia was used in this case and her pulse ran as high as 160 during the operation; I do not believe that a high pulse in these cases is of as serious import as in other conditions; her pulse was rapid for three days then gradually came down to 80 or 90 within a week; in four or five days she began to improve and the improvement was steady as long as she remained in the Infirmary. I understand that she is better still since she left.

Whatever medical treatment can offer I am perfectly willing to accept but your essayist, Dr. Heacock, who is taking care of the medical treatment of the condition does not seem to think very favorably of it in certain cases, he claims benefit by the use of belladonna in diminishing the secretion of the gland, but I am opposed to the long continued use of this drug as it interferes with other normal and needed secretions.

I rather favor ether anesthesia in doing this operation, as it is a major one and it is impossible to do a painless operation with local anesthesia; I believe the excitement due to pain and the thought of having one's throat cut will probably have as much or more to do with increasing the heart beat than the effects of ether.

The greatest advantage of doing it with a local anesthetic is in being able to better tell if the recurrent laryngeal nerve has been caught by the forceps when the inferior thyroid artery is being ligated, in my opinion, the greatest difficulty in the operation is in avoiding this nerve.

CLOSING DISCUSSION.

Dr. Davis:—In reply to the question of Dr. Riggs as to the effect of the suprarenal secretion on that of the thyroid, I cannot do better than to quote Dr. Chas. Mayo, who says in discussing the function and secretion of the thyroid.

"Much has been written on internal secretion and, while our knowledge has continuously grown, there is still very much to learn about the ductless glands. A consideration of the functions of the various structures of the body shows that they are controlled by accelerator and depressor nerves. The stimulating and exhibiting forces. Every muscle action to be effectively controlled is balanced by another which opposes it. In other words, there must be a constant equilibrium of forces. When we consider the effects of the secretion of the suprarenal gland with that of the thyroid, it would seem that in several respects they oppose each other. Such a fact explains, to some extent, the condition of cretinism, in which from lack of a functioning thyroid there is an arrest of development. Through the unopposed action of the suprarenal bodies there is a capillary contraction with circulatory starvation which affects the cerebral cortex, as well as other tissues. The intermittent feeding of thyroid extract causes increased growth and general improvement in appearance, with considerable mental development. The mental development is only sufficient in most cases to convert a passive, helpless imbecile into an active, restless and destructive idiot."

As to the danger of myxedema following the complete removal of the gland, in a few cases where pressure atrophy seems to have destroyed the entire gland in such a way as to lead to a gradual slow withdrawal

of the thyroid secretion, complete removal does not in that class of cases produce myxedema.¹ In a few cases, if not all of the cases where the gland has been destroyed or removed it is possible that accessory thyroids carry on the function of providing the necessary secretion for the system.

Regular Meeting Held March 18, 1907.

The President, Dr. B. L. Wyman, in the chair, Dr. A. F. Toole, Secretary.

The minutes of the last meeting were read and adopted. Subject for the evening, Symposium on Scarlet Fever: Clinical Types, Dr. E. H. Sholl; Differential Diagnosis, Dr. J. H. Edmonson; Complications and Treatment, Dr. W. C. Gewin; Disinfection and Prevention of the Exanthemata, Dr. R. B. Harkness. (See original communications for above papers..)

DISCUSSION.

In discussing these papers Dr. Sholl said: As the general subject is open for discussion, I just wanted to say two things, one of which I regard as important. I had nothing to say as to the treatment particularly, but I just wanted to allude to two things that I think are important. One thing is, the treatment that was used, that I used largely in the old days, when we had smoke houses, and everything was in plenty, the inside of a bacon rind, there were plenty of them (Dr. Robertson knows something about it), and we used to take the inside of a bacon rind and just keep them well greased, particularly among the negroes, as well as among the whites. The hydropathic treatment also, plenty of cold water, externally applied, but the question I want to come to, is one of vital importance, and that is, gentlemen, what should be the conduct of the physician who is treating a case of scarlet fever, in reference to the puerperal woman. That is a subject of vast importance that I would like to hear more of and as that would come under the general head of discussion. I think it is a very important one. I just simply say that notwithstanding all the modern methods, disinfection and baths, and everything else, my rule has been in attending a case of scarlet fever, and in regular attendance, to refuse to attend a woman in child birth. I feel justified in this,—the mere matter of the fee of twenty-five, thirty, forty or fifty dollars was no consideration, taking into account the life of one who might be infected by this dreadful poi-

son. I think it is a matter in connection with scarlet fever that is of vast importance to preach on, so I leave it with the brethren, to give their opinions in regard to it.

Dr. L. Whaley:—I have been very much interested in the papers, but owing to bad accoustics and noise I was unable to hear all that was said. As I understood Dr. Sholl to say in giving symptomatology that the disease was always, or nearly so, ushered in with a distinct chill. This has not been my observation, but to the contrary. A distinct chill being rare among the cases I have treated. It more frequently begins with a slight indisposition for two or three days, or abruptly with nausea and vomiting, and sometimes with convulsions in young children. There may be cases of very mild type with slight eruption and very little sore throat and yet there may be cases following it in the same family that may prove fatal. I hoped to hear malignant scarlet fever in its different forms with complications and sequelae discussed, to-wit: The atactic form with its characteristics of acute toxæmia. Fever rising rapidly to 107° or 108° and death coming on in from 24 to 36 hours due to the intensity of the poison. Another form I would mention is the hemorrhagic form where hemorrhage occurs in the skin with hematuria and epistaxis. Death may occur on the second or third day. This form is perhaps more common in enfeebled children, but occasionally occurs in healthy children. Then the anginosae form where the throat symptoms may appear early and progress rapidly. Membranous exudations occur and may extend to the posterior wall of the pharynx and forward into the mouth and upward into the nostrils. The constitutional symptoms profound and the child dies with the clinical picture of a malignant diphtheria. The practitioner may be in doubt as to whether he is dealing with a case of scarlet fever with intense membranous angina or a true diphtheria with an erythematous rash or coexisting scarlet fever and diphtheria. Scarlet fever and diphtheria may coexist, but in a case presenting erythema and extensive membranous angina with *loefflers baccilla* would puzzle the most scientific expert to say whether the two diseases coexist or whether only an intense scarlatinal rash in diphtheria. Desquamation occurring in either case. In reference to the rheumatic form—that may occur as an acute rheumatism; but doubtful as to whether it is rheumatism or not. It is more analogous to that of gonorrheal rheumatism as it

often occurs in one or two joints only. I agree with Dr. Harkness with reference to rubbing the body well with some antiseptic oil. I would use it three or four times daily after desquamation has set in and before for two reasons. It makes the patient more comfortable by allaying the itching and relieving nervous tension during stage of high fever. Second, it prevents the diffusion of scales and thereby lessens the danger of the spread of the disease.

Dr. S. L. Ledbetter:—In speaking of the question of throat complications briefly, I just want to report one case that illustrates several points. Last year a young married woman came to my office; she had been out driving, and stopped by the office to have me see her throat. On examination I found both tonsils had patch on them; looked like the beginning of an ugly case of tonsillitis, or possibly diphtheria, but resembled more, certain types of tonsillitis. On the following morning had an early call to go up and see her, as she was suffering a good deal with her throat. I stopped in, found conditions pretty much the same; there was a little more necrosis of tissue, a condition which I had still seen in some cases of tonsillitis, so I treated her throat again, and the following afternoon I went up and gave another application. The condition of the necrosis was getting a little more extensive, and there was some little bit of swelling in the neck. The following morning I came again, having been telephoned that she had had a bad night, and wanted some relief. That was perhaps the third day of the case, and when I arrived they called my attention to the fact that she had a little eruption on the inner side of the arms, and under the knees. I looked at it, and as she had been taking antipyrine and sod. salic., I thought possibly that might be the cause of it, but the following morning the temperature was still high, and the eruptions spreading, so the case began to look rather suspicious to me of scarlatina, although I had not suspected it before. I had them send for Dr. Pressley, their family physician, and I reported to him what I suspected. He went out in the afternoon, and telephoned me later that it was scarlet fever. She went on with the regular course of scarlet fever, eventually having the exfoliation, etc. Later I saw her again, with the family physician. She was suffering from abscesses of the glands with considerable cellulitis. And at the same time I was told that she was suffering intensely from pains in her arms, shoulders and legs, that were either

rheumatic or conditions of neuritis or something, I think Dr. Wilson claimed that it was rheumatic. So that that case illustrated this point, that scarlet fever can begin at first with what seems to be an ordinary case of tonsillitis, or what might be a case of diphtheria and scarlet fever complicated. Examination, however, showed no bacilli, and eliminated that element, of diphtheria. Another thing, the baby, the young woman had a young baby about a year old, which was nursing, and until I had seen her the following morning, nothing was said about removing the baby from the mother. However, when I saw her on the following morning, I advised them that it might be a rather serious matter, and they had better keep the baby away from her, so they kept the baby in an adjoining room, and the grandmother, who looked after the baby, kept away from the sick room. After it was diagnosed scarlet fever, the baby was sent away from the house altogether. As to the time at which the disease is the most contagious. Now, I think if the disease is contagious to any considerable extent in the early stages, that baby would have had it. Of course the baby sleeping with the mother and nursing the mother would come in as close contact as it were possible for one person to come with another, and for at least two days of the time of the mother's sickness, the baby was in constant contact with the mother, as all babies are, sleeping in the same room, nursing the mother, and being handled by the mother. That child did not have scarlet fever at all. Now, I think if that child had come into the room later on after the period of exfoliation had begun the chances would have been that the child would hardly have escaped from contracting the disease. That is a point I did not hear brought out at all; the question of what time the disease is most likely contracted. Then, as to the condition, that comes in the tonsils, and which develops the deep seated abscess. The secretion from these tonsils showed no bacilli, but the different kinds of cocci, and the poisoning that comes from that, as Dr. Whaley says, I think very likely is a septic condition, and not a condition due to the disease per se, or to the specific scarlet fever poison. In reference to the fatality of the disease. I suppose Dr. Sholl would call the fatal cases complicated, not simple. I perhaps have seen fifteen or twenty cases of scarlet fever, probably more than that, two dozen cases all told. I think I have seen seven or eight deaths all told. All of those cases have been in

consultation and were violent types with extensive swelling of glands of the neck. I saw a case recently at Pratt City, in consultation, in which the swelling was very considerable, and in which the tissues were lanced without bringing any pus whatever. It was a condition of general cellulitis, not a distinct abscess; never discharged. The child went along and died, apparently from septic poisoning, after, I think, about the third week of the disease when the scarlet fever had subsided, the eruptions had disappeared, and the exfoliation had gone very far towards passing away. It was about the end of the third week the child died, so that it evidently died from the septic condition, and not from scarlet fever poison direct. The ear complications, I think I won't talk about that; I have said enough.

Dr. W. H. Wilder:—There is one practical side of this question that I want to ask Dr. Harkness to bring out in his closing remarks, and that was what diseases are quarantinable according to our city ordinances; what cases really are to be reported to the city health officer, and also what period of time these cases are to be confined in their homes. I am very sorry Dr. Ledbetter did not continue further, and tell us something more about the ear complications. The theoretical side of this thing has just been barely touched upon by Dr. Harkness and Dr. McAdory. I should not be surprised in a few years, if all our theories would be upset completely. You know, we do not have the same ideas at all now in regard to yellow fever that we did ten years ago. I noticed recently a brief article on the subject of contagiousness, especially of scarlet fever. Now, the question is, how a patient takes scarlet fever. We know very little about it. It is commonly believed that patients take it by coming in contact with each other or with something touched by a scarlet fever case, by fomites fever through the blood seems certain; most of us have seen cases where a patient with an open wound has taken scarlet fever. There are cases reported of where children have been born in various stages of scarlet fever. I have never seen one myself, in fact I have never had an opportunity. While I had charge of the small pox camp there was a negro baby born in the camp, and the mother of it had a well marked case of small pox, still the baby was as clean of any eruption as any baby you ever saw. It was perfectly healthy. I vaccinated it the day it was born in the camp, and it never took any disease at all.

Another thing that struck me in reading a recent article on scarlatina was that some experiments have been made in regard to serum. They are trying to get serums now for everything. I believe it was Moser of Vienna, that took the serum of a patient that was convalescing from scarlet fever, injected into a horse, and then afterwards took this serum from the horse and injected into other patients that had scarlet fever and children that were exposed to scarlatina, and it is marvelous what claims they make for it, and then on the other hand, you will find men who claim that they tried the same thing, and did not get any results. Moser of Vienna, and Charlton of Montreal, are two men who have made a good many experiments with the serum of scarlet fever, and they have claimed almost as marvelous results, as have been gotten from diphtheria with antitoxin.

THE BIBB COUNTY MEDICAL SOCIETY.

The Bibb County Medical Society held its quarterly meeting at Blocton on April 2nd. There were present sixteen of the members and three visiting physicians from Birmingham. The minutes of the last meeting were read and approved. The message of the retiring president was reviewed and the changes suggested by him were adopted. The retiring president, Dr. J. F. Jenkins is to be congratulated, on the excellent work of the society during the year. The present president, Dr. J. F. Alexander, will from the start made keep up the standard. The Bibb Society has for several years ranked second to none except in number of its members. The friendship and brotherly love existing between the doctors is indeed gratifying. The fact that two-thirds of the applicants to practice medicine in the county were rejected during the past year shows the high standard held by the board.

Dr. J. F. Jenkins read an excellent paper on Hepatic Syphilis, reporting several cases. One of the cases he saw operated on where the mistaken diagnosis of tumor of the liver had been made. Nothing was done at operation, and the patient improved rapidly on large doses of potassium iodide and mercury. He warns against mistaking a hard syphilitic gumma of the liver for a surgical lesion. Dr. W. G. Harrison of Birmingham, read a very interesting paper on Mouth Breathing, showing the disastrous results by exhibiting a patient who suffered with adenoids which were neglected till patient was nineteen years old,

resulting in physical deformity as well as mental defectiveness. He emphasized the importance of early operating on these cases, as they are specially liable to contract infectious disease, particularly tuberculosis, as well as result in the lack of physical and mental development if neglected.

After the discussion of these papers the members and visitors repaired to the banquet hall where a most excellent feast had been prepared by the president, Dr. Alexander. The clock pointed to the small hours of the morning when the guests and members left the banquet hall, feeling that the meeting had been both pleasant and profitable, and that the society and president had both done themselves proud.

THE COLBERT COUNTY MEDICAL SOCIETY.

At the annual meeting of the Colbert County Medical Society held in Tuscumbia the following officers were elected for the year: President, Dr. T. H. Henry, Tuscumbia, Ala.; Vice-president, Dr. J. T. Haney, Tuscumbia, Ala.; Censors, Dr. H. W. Blair, Sheffield, Ala., and Dr. Morris Henry, Tuscumbia, Ala.

THE COOSA COUNTY MEDICAL SOCIETY.

The Coosa County Medical Society met in Rockford on Tuesday, April 2d with Dr. Julius Jones, President, in chair. The president delivered his retiring message, and the following officers were elected for the ensuing year: President, Dr. W. A. Holloway, Lauderdale, Ala.; Vice-president, Dr. C. K. Maxwell, Kellyton, Ala.; Censors, Dr. Eugene Argo, Goodwater, Ala.; delegates to the State Medical Association, Dr. J. C. Cousins, Equality, Ala., and Dr. J. W. Maddox, Traveler's Rest, Ala.

THE DEKALB COUNTY MEDICAL SOCIETY.

At the annual meeting of the DeKalb County Medical Society held in Fort Payne the following officers were elected: President Dr. S. J. Vann, Collinsville, Vice-president, Dr. W. S. Duff, Ft. Payne, and Secretary and Treasurer, Dr. W. E. Quinn.

THE MORGAN COUNTY MEDICAL SOCIETY.

Morgan County Medical Society meets in regular session first Thursday in each month. The following officers were elected for 1907, to-wit: President, Dr. A. R. Wilson, Hartselle; Vice-president, Dr. B. W. Watson, New Decatur; Secretary and Treasurer, Dr. J. S. Gunter, New Decatur; County Health Officer, Dr. S. L. Rountree, New Decatur, R. F. D. No. 2.

At our February meeting a resolution was adopted making five (\$5.00) dollars the minimum fee for examining for old line insurance companies and signed by the following: Decatur, Drs. W. L. Dinsmore, E. J. Canyngton, J. F. Myers, W. H. Watson; New Decatur, H. T. Bracken, Jno. B. Shelton, B. W. Watson, C. S. Chenault, F. L. Chenault, F. P. Petty, J. L. Gunter; Hartselle, H. C. McRee, A. R. Wilson, W. M. Booth, R. B. Sherrill, T. B. Brindley; Woodland's Mill, T. J. Russell; Falkville, W. L. Stringer.

In the near future we will adopt a "post graduate course" in connection with our regular monthly meeting: having clinics in lieu of papers.

At our April meeting Dr. F. P. Pettey presented a clinic, showing recovery from a large liver injury. The injury was a large triangular incised, contused wound of liver, right lobe 4 in. x 4 in., with evisceration of part of stomach, made Dec. 5, 1906, by a flying piece of steel driven from a steam punch.

OBSERVATION.

Such a patient should be handled just as little as possible, to avoid shock, hemorrhage and sepsis. If bile is to flow into the general peritoneal cavity, very ample drainage should be provided because it is an irritant to peritoneum and causes excessive flow of peritoneal fluid. It is not septic primarily and need not be feared for this reason. Of course it should not be allowed to become septic. Peritoneal fluid is very softening to absorbable catgut and this material should not be trusted, and even in an emergency a little delay may justifiably be incurred to secure other material. Where used to close the abdominal wound around the large drainage the peritoneal fluid soften and gave way in 36 hours allowing a gaping wound 1 1-2 to 2 inches in diameter. Into this large abdominal opening the omentum presented attached it-

self to edges, protected the viscus, took on healthy granulations, and over its surface the abdominal wall closed and shut the omentum in, all of which was a beautiful illustration of what the omentum will do. It feeds the gut and fights for it and settles many a little question for the good of the surgeon and patient too. Bile ceased to flow from this liver wound in the fourth or fifth day, the ducts having closed their mouths and a process of repair being begun.

The stomach emptied itself of a large meal after it was returned to abdomen while patient was under anaesthetic. This was an agreeable occurrence as otherwise it had been imperative to wash the stomach of all undigested matter, to prevent subsequent gass formation which, in the absence of bile in the intestine would have been a source of great annoyance and even might have affected a fatal issue.

This patient was allowed nothing but sips of hot or cold water for 48 hours. Small enemas were given, careful dieting for ten days, only such articles as do not require bile for their digestion were permitted—beef extracts, egg albumen, etc. No gas accumulated in bowels. Patient complained very little of pain from the beginning to the end of illness. Had a pain in right shoulder. The liver is now normal in size, function and sensation. The patient is bright and cheerful and never was otherwise, though he became markedly jaundiced. The injury wound was only used for drainage. I rather think we had done better to have made an opening just under the liver—posteriorly—still in shock traumatism should not be permitted if possibly avoidable.

THE SUMTER COUNTY MEDICAL SOCIETY.

At a meeting of the Sumter County Medical Society held on the 9th of April the following physicians (which includes the entire membership of our society) pledged themselves not to make any examinations for old line life insurance companies for less than \$5.00: J. K. Miller, M. D., Sumterville; A. D. James, M. D., York; J. C. McDaniel, M. D., Gaston; R. E. Hale, M. D., Bellamy; A. L. Vaughan, M. D., Cuba; R. E. Harwood, M. D., Gainesville; Q. R. McLean, M. D., Gainesville; S. S. Swain, M. D., Ramsey; John T. Seales, M. D., Coatopa; D. S. Brockway, M. D., Livingston; W. J. McCain, M. D., Livingston; J. M. McElroy, M. D., Cuba; R. H. Hale, M. D., York; W. T. Cocke, M. D., Livingston; F. L. Hester, M. D., Belmont.



Editorial.

W. H. BELL, M. D., Editor.

COLLABORATORS:

T. W. Ayers, M. D., Hwang-hien, via Chefoo, China.
J. T. Searcy, M. D., Tuscaloosa
L. C. Morris, M. D., Birmingham.
J. A. Goggans, M. D., Alexander City.
W. W. Harper, M. D., Selma
Frank T. Smith, M.D., Chattanooga, Tenn.
E. D. Bondurant, M. D., Mobile
B. L. Wyman, M. D., Birmingham
Thomas D. Parke, M. D., Birmingham, Ala.
W. H. Wilder, M. D., Birmingham,
D. F. Talley, M. D., Birmingham.

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20th St., Birmingham, Ala.

The Meeting of the State Association.

The meeting of the State Medical Association held in Mobile April 16th to 19th was a very pleasant and successful one, with a good attendance. The hospitality shown the visitors by the profession and people of Mobile was characteristic of that Southern city by the gulf.

The social side of the meeting was a great success. The boat-ride down the bay on Tuesday afternoon, the reception at the Elks' club Wednesday evening and the annual banquet at the German Relief Hall Thursday evening comprised the public functions, while many of the visitors were privately entertained.

In order that every paper might be read during the meeting, the president, Dr. G. T. McWhorter, in arranging the scientific program

provided for a smaller number of papers than has been customary for several years. And perhaps for the first time in years every one on the program had an opportunity of reading his paper.

The Association was fortunate in having as the Jerome Cochrane Lecturer this year a man so eminent and learned in his profession as Dr. Nicholas Senn of Chicago. His address on "The Final Triumph of Medicine" was a distinct feature of the meeting, and was enjoyed by every one present. At the conclusion of his address he was extended a rising vote of thanks by the Association.

Another paper of unusual importance and interest was that of Dr. C. C. Thach, President of the Alabama Polytechnic Institute at Auburn, upon "College Training for Medical Students."

Dr. W. D. Haggard of Nashville, Tenn., was another visitor who favored the Association with a paper.

The president's annual message was a well written address, characterized by no revolutionary suggestions or recommendations. After congratulating the profession and the people of the State upon the prevalence of good health during the year and the absence of widespread epidemic disease; and referring to the rapprochement between the people and the medical profession, and the good will and confidence existing between the profession and the legislative body of our State; he suggested that the profession should assume its proper position in political and state affairs. He recommended that the Association record its endorsement of the establishment of a national department of public health, with a physician at its head in the cabinet of the President of the United States. He told of the increase of the annual appropriation from \$4,000.00 to \$15,000.00, by the legislature, for the use of our State Board of Health in the enforcement of our health laws; of the probability of the passage of the bills establishing an epileptic colony and a tuberculosis sanatorium in the State; and also of the probability of the passage of the bill to regulate the practice of medicine in the State relating to the abolition of county boards of examiners and establishing one State Board.

Resolutions were adopted by the Association recommending to the Board of Health an increase in the salary of the State Health Officer from \$2400.00 to \$5,000.00 per annum. Upon the suggestion of the

Health Officer himself his salary was fixed at \$3600.00. He unselfishly claimed that the balance should be used in promoting the interests of the health department of the State.

Resolutions, which we publish elsewhere, were also adopted by the Association endorsing the minimum fee of \$5.00 for life insurance examinations.

Montgomery was selected as the place of meeting for 1908, and the officers elected are as follows: President, Dr. S. W. Welch, Talladega; Sen. Vice-president, Dr. A. J. Coley, Alexander City; Jr. Vice-president, Dr. S. C. Henderson, Brewton; Censors for five years, Drs. W. H. Sanders, Mobile, and M. B. Cameron, Eutaw; Censor to fill the unexpired term of Dr. Welch, Dr. Glenn Andrews, Montgomery; Orator, Dr. W. P. McAdory, Birmingham; Alternate Orator, Dr. Wm. D. Partlow, Tuscaloosa.

Pleuritic Effusion, Empyema and Gangrene of the Lung.

The progressive medical man is aware that it is of great importance that pleuritic effusions should not be allowed to remain long in the pleural cavity. And if absorption of the fluid be delayed beyond a week or ten days aspiration or rather measures for its removal should be employed. One rule adopted by all practitioners is to remove the fluid as soon as pressure symptoms are noticed either from lungs or heart. But there are some cases in which quite an extensive effusion may be present and no subjective symptoms be very marked either in the cardiac or respiratory action. It is a fact that when permitted to remain the fluid usually becomes converted into pus and it should at once be drained. We can practically have no hope of pus in the pleural cavity undergoing absorption, but may rather expect the condition to grow progressively worse resulting in the destruction of the entire lung and consequent death of the patient.

Hare in *Therapeutic Gazette* says that the greater number of pleural effusions which require treatment by instrumental means depend upon an infection of the pleural membrane and not upon simple transudation, and it is to be remembered that most of these cases depending upon infection have present not only fluid in the pleural cavity, but a con-

siderable formation of lymph exudate over the surface of the pleura, which renders absorption slow or impossible. In other words, this teaches that purgatives, diuretics and diaphoretics can do little good in this condition.

We have recently observed two deaths where the physicians in charge had placed all confidence in the purgative and diuretic treatment of a pleuritic effusion and did not wake up to the uselessness of his endeavors until the patients in both instances had become so profoundly septic and had so much lung tissue destroyed by the suppurative process that operation was deemed of no value and refused. If these had been subjected to an early operation the two lives might have been saved. Aspiration before pus formation would perhaps have been all that might have been required.

In aspirating a large pleuritic effusion the same rules should be observed as in removing large accumulations from the abdominal cavity. Some surgeons produce quite a vacuum before permitting the flow to begin, thus removing the accumulation much more rapidly, but in this condition as in that of the abdomen, syncope may occur from the too rapid removal of pressure from the great vessels of the thorax.

As to when a pleuritic effusion will develop into an empyema we are of course unable to say; but empyema is a disease so frequently encountered and the fact so often overlooked that it is well to be on guard at all times where any disease of the thorax is dealt with. Of course the use of the aspirating needle is the surest method of arriving at a positive diagnosis as to accumulations in the lung cavity; but the ordinary hypodermic syringe as used by many is almost useless, as the needle may be too short to pass into the thoracic cavity, or if pus be present the fluid too thick to pass through the small needle.

J. N. Hall in a very interesting article in the *International Clinics* says the best place to aspirate "is always in the center of the largest area of flatness regardless of the number of the interspace or other landmarks."

The use of the aspirator as a curative measure for empyema should never be employed, and although claimed by Fetra, Lloyd and others to have given good results, it seems much more rational to secure free drainage by resecting a section of the rib leaving an opening large enough for free drainage.

Gangrene of the lung is usually very easily diagnosed by its very offensive odor. It is a very fatal disease, but the patient should always be given the benefit of an operation. We have seen two cases operated on in which the lung had in each case a cavity larger than an orange. In one the recovery was good, the other died in twelve hours after operation. The temperature, pulse and respiration in both these cases were very much exaggerated, and it seemed the operation offered little hope. The only criticism to be offered concerning the first operation (with which the operator agreed) was that too much was done after resecting the rib; much of the dead tissue was clipped away and some portion removed with a spoon. The protective wall that nature had thrown around the infected area was in this way broken up and more poisons let into the blood stream. In the second case nothing was done except a resection of the rib and a large drain left in, and the patient begun to improve at once and in the course of time made a complete recovery. At the time of operation the condition of this latter case seemed to offer less hope for recovery than that of the former. The cause of gangrene of the lung is the entrance, under favorable conditions for their existence and multiplication, of putrefactive bacteria. It is one of the terminations of pneumonia, which results from a lack of sufficient blood supply to the parts that are so intensely engorged. It is more often seen in people of advanced years, intemperate habits or those suffering with some chronic wasting disease. It is said that in the majority of cases the putrefactive bacteria enter the lungs through the air passages, although it is possible for them to be carried there through the lymphatics or the blood stream. But the manner in which this and other conditions are brought about does not concern the general practitioner so much as the diagnosis of these conditions when present so that valuable time may not be lost in resorting to proper treatment.

The Birmingham Medical College Commencement Exercises.

The exercises of the thirteenth annual commencement of the Birmingham Medical College and College of Pharmacy were held at the Jefferson theater Wednesday evening, April 10th. The past year has been one of the most successful in the history of the institution, and a

list of fourteen graduates in medicine and four graduates in pharmacy received their diplomas.

A large audience greeted the dean of the college, Dr. B. L. Wyman when he introduced Rev. J. A. Duncan, D. D., who pronounced the invocation.

The speaker of the evening, Col. T. G. Bush, followed with the annual address to the class, which was a brilliant effort, full of humor, sound advice and enthusiastic encouragement to the young doctors.

Dr. Wyman then conferred the degrees upon the two classes and after a brief address of congratulation called on Dr. R. M. Cunningham of the faculty to deliver the charge to the graduates, which he did in his inimitable and eloquent way.

Following is a list of the graduates:

Medical Graduates—J. S. Cleveland, J. B. Gregory, H. A. Griffith, E. N. Harris, W. F. Hamilton, O. C. McCorn, A. D. McLain, W. T. Miller, R. H. Puckett, H. J. Swellow, J. A. Wheeler, H. C. Wickle, M. B. Williams, W. E. Wright.

Pharmacy Graduates.—H. C. Hillhouse, J. L. Johnson, J. A. McNeal, J. I. Isaacs.

We have received a communication, too late for publication in this issue, from Dr. Geo. S. Brown of Birmingham replying to our leading editorial on "The Medical Association of the State of Alabama" in the April number. We will publish this in our next number.

The Publishers of *Annals of Surgery* have announced a special Number for June. From the announcement it will be a remarkable collection of the choicest literature on modern surgery. Each article will be a practical, comprehensive treatise of an eminent specialist who has actually performed the operations described. No expense will be spared to make this the best issue, completing the forty-fifth volume.

Reviews of Books, List of Contributors and a Volume Index complete the book, a work alike creditable to the surgical profession, the editor and the publishers.

Dr. A. T. Osgood, of New York City, has an excellent paper on *The Diagnosis of Obscure Cases of Renal and Ureteral Calculus*,

Dr. Nathan Jacobson of Syracuse, N. Y., discusses Toxic Nephritis Dependent upon Surgical Conditions.

Dr. E. L. Keyes, of New York, reports observations on a hundred patients suffering from Tuberculosis of the Testicle.

Dr. Clarence A. McWilliams, of New York, has an article on Primary Typhlitis without Appendicitis.

Dr. Jno. A. Bodine, of New York City, reports over four hundred operations for Radical Cure of Inguinal Hernia with Local Cocaine Anesthesia.

Dr. J. Collins Warren, of Boston, opens the number with Plastic Resection of the Mammary Gland.

Dr. Wm. J. Mayo, of Rochester, Min., has an article on Treatment of Acute Ulcer of the Stomach.

There are other papers by other prominent surgeons, but these are sufficient to show the character of the number. The price is one dollar. The editor is Dr. L. S. Pilcher, and J. B. Lippincott Company are the publishers.

Resolutions introduced by Dr. Seale Harris at the meeting of the State Medical Association in Mobile with amendments, adopted.

Whereas, It is the unanimous opinion of the 1800 members of the Medical Association of Alabama that the minimum fee for life insurance examinations should be \$5.00; be it resolved,

First, That the members of this Association are urged to make no examinations for life insurance for less than the fee above stated.

Second, That the County Medical Societies should separately and individually adopt this minimum fee.

Third, That the delegates to the American Medical Association are instructed to urge that body to consider this question at the coming meeting.

Amendment by Dr. Cameron:

Amended by inserting at the proper place the words, "to be paid by the company."

Amendment by Dr. Inge:

That the Secretary of the Alabama Medical Association at once notify all companies that have less than \$5.00 as a minimum charge of our action.

Personal Notes.

Dr. J. E. Garrison of Quinton, was in the city a few days ago.

Dr. R. H. McGehee, of Abernant, was in Birmingham a few days ago.

Dr. Geo. S. Brown, who spent a few weeks in Virginia, has returned to the city.

Drs. C. P. Martin and J. N. Ray, of Woodstock, were in the city for a few hours on the 15th.

Dr. J. H. Howle of Eclectic, Elmore county, called on us while in Birmingham recently.

Dr. W. C. Head, of Johns, was in to see us a few days ago. We always enjoy the doctor's visits.

Dr. J. W. Barclay, of this city visited relatives and friends in Huntsville for a few days last month.

Our old college friend, Dr. E. A. Matthews, of Clanton, was in the city on business on the 27th and 28th.

We had very pleasant calls from Dr. W. C. Williams of Shelby and Dr. J. F. Alexander of Blocton a few days ago.

Dr. W. H. Sanders, the State Health Officer, stopped over in Birmingham a few hours on his return from Jasper on the first of the month.

Dr. T. E. Schoolar, a prominent physician and druggist of Centerville, visited friends and relatives in Birmingham for a few days last week.

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Dr. J. H. Gunn, of Calera, the very efficient Secretary of Shelby County Medical Society, was in Birmingham on business a few days ago.

We had a very pleasant call a few days ago from Dr. D. L. Wilkinson, the physician for the Alabama Industrial School for Girls at Montevallo.

Dr. J. F. Curtis of Blocton and Dr. A. M. Stovall of Jasper attended the meeting of the Jefferson County Medical Society last Monday evening.

Dr. Holland of Bloomington, Ind., has been a visitor to friends in Birmingham during the past month, and while here visited the Jefferson County Medical Society.

Dr. W. A. White, Superintendent of the Elizabeth Hospital for the Insane at Washington, D. C., was in Birmingham as expert witness in the Chisolm case in the early part of the month.

Drs. J. T. Searcy and Wm. D. Partlow, Superintendent and Senior Assistant Physician respectively to the Bryce Insane Hospital at Tuscaloosa, were in attendance as expert witnesses in the Chisolm case in the city a few days ago. While here they attended a meeting of the Jefferson County Society.

The Lady Board of Managers of the Hillman Hospital of this city has transferred that institution to the Board of Revenue of Jefferson county to be used exclusively as a charity hospital. A Board of Directors has been chosen composed of the following: Mr. Job Going, Chairman, Dr. E. P. Riggs, Dr. T. D. Parke, Dr. D. F. Talley and Dr. Hardee Johnston.

Dr. W. L. Heflin, of Roanoke, Ala., was in Birmingham for several days during last month. He was here to attend the annual reunion of his family, which was quite a notable event, celebrating his 79th birthday. We hope the doctor may live to enjoy many more happy occasions of this kind.

Book Notices.

Medical Diagnosis.—Clinical Methods for Practitioners and Students.

Fifth Edition. Enlarged and Revised to date. By J. J. Graham Brown, M. D., F. R. C. P. E., F. R. S. E., Assistant Physician Royal Infirmary of Edinburg, and W. T. Ritchie, M. D., F. R. C. P. E., F. R. S. E., Clinical Assistant Pathologist, Royal Infirmary of Edinburg. With 200 illustrations and 8 full page plates in black and white and in color. Price \$3.00. Imperial Publishing Company, New York. 1907.

The value and popularity of this book is attested by the fact that it has gone through four editions. In this fifth edition "every section has been carefully revised, and in almost every case considerable additions have been made." We commend the book to both the physician and student. It will be of value to the physician when in need of quick, concise and up to date information about Medical diagnosis.

International Clinics.—A Quarterly of Illustrated Clinical Lectures and Especially Prepared Original Articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene, and other topics of interest to students and practitioners. Edited by W. T. Longcope, M. D., Volume 1. Seventeenth Series, 1907. Philadelphia and London: J. B. Lippincott Co. (Cloth \$2.00.)

This is a very interesting volume containing articles by Barker, Dennis, Walsh, Norris, Morton, Senn, Gallant, DeSchweinitz and others. The progress of medicine during 1906 is given, Stevens contributing the article on Treatment, Esdall and Nisbett that on Medicine, and Bloodgood the one on Surgery.

This volume is well up to the standard and should be in every physician's library.

Tuberculosis as a Disease of the Masses and How to Combat it.—

Fourth Issue Revised and Illustrated, with supplement on Home Hygiene, School Hygiene, Installation of the Sanatorium Treatment at home, and a historical review of the anti-tuberculosis movement in the United States. Prize Essay by S. A. Knoff, M. D., New York. Published by Fred P. Flori, 514 E. 82d st., New York. (Paper bound 25 cts., cloth bound 50 cts.)

This is a well written essay on a subject of great importance and should be read by layman as well as by physician. The great mortality and fearful ravages of tuberculosis justify a vigorous crusade against it. The author believes in an ultimate eradication of the disease, and says that all that is required to attain this goal is the combined action of a wise government, well trained physicians, and an intelligent people. His expressed desire is "that this fourth issue, which is enhanced in value by the supplement, may meet with the same kind reception that has been accorded to the previous editions, and that the information which the book is intended to convey may be helpful to physicians and patients, teachers and parents, statesmen, employers and employees, to rich and poor, in short to all able and willing to help in the solution of the tuberculosis problem, and thus add to the health, prosperity and happiness of all the people."

PUBLICATIONS RECEIVED.

P. Blakiston's Son & Co., Philadelphia. 1906 and 1907.

A Manual of Pathology.—Martin.

The World's Anatomists.—Komper.

Minor Surgery and Bandaging.—Heath.

Quiz Materia Medica. Therapeutics and Prescription Writing. 7th ed.—Potter.

Pocket Pronouncing Lexicon.—Gould.

Students Medical Dictionary.—Gould.

Bacteriology.—Smith.

Malformations of the Genital Organs of Woman.—Debierre.

Lea Brothers & Co., Philadelphia. 1906. Gray's Anatomy, New American Edition.

The American Society of Tropical Medicine. Papers read before the society and published under its auspices. Volume 2. 1905-1906.

Mortality Statistics. 1905. Sixth Annual Report with revised rates for intercensal years 1901 to 1904 and for quinquennial period 1900 to 1904 based upon State Censuses of 1905. Washington. Government Printing Office. 1907.

Transactions of the Thirty-seventh Annual Session of the Medical Society of Virginia, held in Charlottesville, Va., Oct. 9-11, 1906. Williams Printing Co., Richmond, Va.

Scarlet Fever. Its Prevention, Restriction and Suppression. Published by the Illinois State Board of Health. 1907. Revised Edition.

Diphtheria. Its Prevention, Restriction and Suppression. Issued by the Illinois State Board of Health. 1907. Rev. Ed.

Thirty-Third Annual Report of the Medical Director of the Cincinnati Sanitarium for the year ending Nov. 30, 1906.

The Influence of Flesh-Eating on Endurance. By Irving Fisher, Prof. of Political Economy at Yale University.

America's Amazing Advance. By Richard H. Edmonds, Manufacturer's Record, Baltimore, Md. 1906.

Annual Report of the Library Committee of the College of Physicians of Philadelphia for the year 1906.

The Timber Supply of the United States. By R. S. Kellogg Forest Inspector. U. S. Dept of Ag. Forest Service.

Address of the Standing Committee on Tuberculosis of the Medical Ass'n of the State of Alabama to the Members of the State Legislature, Feb. 4, 1907.

REPRINTS.

(1) Chronic Non-Tubercular Affections of the Lung. (2) The care of Far-advanced cases of Pulmonary Tuberculosis. (3) What May be Accomplished with apparently Hopeless Cases of Tuberculosis. By Sherman G. Bonney, M. D., Denver.

Trypsin in Cancer. By W. S. Bainbridge, M. S., M. D., New York.

What Can the Organized Medical Profession do to Aid in the Suppression of Quackery? By Henry W. Cattell, A. M., M. D., Philadelphia.

Miscellaneous Notes.

The sudden death of Mr. Theodore D. Buhl, the President of Parke, Davis & Co., occurred on April 17th. He had been connected with the company for ten and a half years.

Aletris Cordialrio represents one of our most reliable indigenous agents for uterine ailments. Reports of its efficacy in numerous cases of amenorrhea, dysmenorrhea and menorrhagia affirm its value in the treatment of these cases.

The physician who employs Peacock's Bromides can depend upon best possible bromide results. This preparation never varies in strength and eminent American and English analytical chemists have testified to the extra purity of the salts entering its composition. It has long been and will continue to be an important consideration to neurologists and general practitioners who wish to resort to a continued bromide treatment.

To guard the functions of the heart is characteristic of the therapeutic action of Cactina Pillets. This conclusion reached by Myers by more than fifteen years ago has been fully sustained by clinical experience. According to Myers, its power to increase the muscle—motor energy of the heart, elevating the arterial tension and increasing the height and force of the pulse wave, makes it a cardiac tonic stimulant of importance in the treatment of irregular and feeble heart action.

SANMETTO IN PROSTATIC IRRITATIONS, URETHRAL AND BLADDER TROUBLES.

I have used Sanmetto extensively in my practice in prostatic irritations, urethral and bladder troubles, and am well pleased with the results obtained. In cases where the drug is indicated I always feel confident of obtaining good results.

J. A. Downey, M. D.

Logansport, Ind.

Alabama Medical Journal, Birmingham, Ala.

On the morning of March 4th we were visited by fire, which practically destroyed the manufacturing end of our business. We had, however, a duplicate plant in storage and are pleased to state that after four days and nights of continuous work we were again turning out Glyco-Thymoline. We regard this as a record.

Yours very truly,

Kress & Owen Company,
Samuel Owen, President.

Dallas, Texas, Oct. 31, 1906.

The Anasarcin Chemical Co.,
Winchester, Tenn.

I herein acknowledge receipt of Tablets sent me some time ago, and I am glad to say that I never used a medicine in Dropsy resulting from Heart Trouble with more satisfactory results. I shall prescribe them hereafter in all similar affections.

Yours truly,

J. W. Anderson, M. D.

COCA AND THE SALICYLATES.

J. H., Cincinnati, O., writes to the editor of The Coca Leaf: "Following a suggestion in The Coca Leaf as to the depurative action of Coca, I have used Vin Mariani to assist the elimination of uric acid, giving the wine either alone or alternately with the salicylates. I wish to express my appreciation of this remedy, which has opened a field of usefulness to me."

It is equally pleasant to record as to give kindly suggestions. Attention directed to the applications of Coca, will indicate many uses for this remedy which will prove satisfying to both patient and physician.

The indescribably depressing action upon the stomach, often complained of by patients who take salicylates, may be obviated by using Vin Mariani as a vehicle. Fifteen or twenty grains of salicylate of soda in two ounces of Vin Mariani affords a palatable and efficient remedy in the elimination of uric acid. This dose may be found serviceable twice daily, after eating, and again at bed time if indicated.—The Coca Leaf, March, 1905.

SANMETTO IN PROSTATITIS, CHRONIC CYSTITIS AND
ENURESIS.

I have had a very large experience with Sanmetto in prostatitis so common in old men, also in chronic cystitis in both sexes, and find it prompt, efficient and reliable in these and in all other cases of irritability of the genito-urinary organs. Have also used it with great satisfaction in enuresis; in fact, I think it will cure any case where no mechanical cause exists.

Edw. J. Libbert, M. D.

Aurora, Ind.

Stone Ridge, N. Y., Nov. 27, 1906.

The Anasarcin Chemical Co.,
Winchester, Tenn.

The sample "Anasarcin" you so kindly sent me I used upon the following case: P. J., male, merchant, age 65; heart dropsy; limbs swollen to knees very badly; compelled to bandage them; very short of breath; could not lie down; what little sleep he obtained was had sitting in chair. His family gave up all hope of his recovery. On the morning of the 8th November commenced "Anasarcin," three tablets a day and every other day a tablespoonful sulphate magnesia. On the 18th November discontinued my visits as the swelling had entirely disappeared; he could sleep in bed with comfort; appetite good and patient in excellent spirits. I advised him to continue one tablet of the medicine before each meal three times a day for a few days. Today he is attending to his business as usual and continues in fair health. Prior to using Anasarcin I had about exhausted the list recommended in such cases and given up hope of the patient's recovery.

Very truly yours,

Herman Craft, M. D.

P. S.—You may make use of this letter if you desire.

H. C.

FOLIA UROLOGICA.

With Professor James Israel of Berlin as Editor-in-Chief, Professor A. Kollmann of Leipzig, Dr. G. Kulisch of Halle and Dr. W. Tamm of Leipzig as Associate Editors and the other principal urologists of

Europe as collaborators, these new international archives are announced by the house of W. Klinkhardt, Leipzig. Exhaustive original articles with colored plates and illustrations will be the principal feature of *Folia Urologica*. Contributions will be published in the four languages that are officially used in Congresses and each paper will be summarized in the three other languages. The new publication will contain a department entitled "Events in Urology" in which the regular collaborators will periodically report on the advances in this specialty, after having tested them critically in their respective services and laboratories. Finally *Folia Urologica* is to serve as a means of collecting the Annual Reports on urological work in hospitals, clinics, etc., throughout the world. With a view to publishing contributions as quickly as possible, the issues of *Folia Urologica* will appear as often as required. Contributions from North, Central and South American authors may be sent to either of the American Editorial Representatives, William N. Wishard, M. D., Newton-Claypool Building, Indianapolis, Ind., or Ferd. C. Valentine, 171 West 71st Street, New York.

TONSILLITIS.

Inflammation in any form attacking the tonsillar region gives rise to symptoms of most distressing character and at the same time provides a most favorable soil for the entry into the system of other infections. It is well to remember that at first this disease is only a local disturbance affecting the capillary system and glandular structure and if promptly and efficiently treated will remain local. The constitutional symptoms as fever, headache, etc., only develop when there is considerable infection taken up.

In the treatment the first indication is to increase local capillary circulation. A local remedy must fill two requirements, i. e., a detergent antiseptic and a degree of permanency in effect. Many of the remedies which have been advocated for the various forms of tonsillitis are antiseptic, but they are not sufficiently exosmotic in their action to increase the circulation or else their effect is too transient. Glyco-Thymoline frequently applied in a 50 per cent. strength with a hand atomizer produces a rapid depletion of the congested area through its well defined exostomic property, re-establishing normal passage of fluids

through the tissues, promptly relieving the dry condition of the membrane and giving an immediate and lasting anodyne effect. As a gargle a 25 per cent. solution hot may be effectively used providing the process does not cause undue pain. The external application of cloths dipped in hot water and Glyco-Thymoline in 24 per cent. solution greatly increases the venous circulation.

ANEMIA AND ITS RELATION TO CATARRHAL INFLAMMATION.

No disease is more common than chronic inflammation of the mucous membranes. Doubtless many causes contribute to the prevalence of this malady which spares neither the young nor the old, the rich nor the poor, the high nor the low. Prominent in its etiology, however, are sudden climatic changes, the breathing of bad or dust laden air, bad hygiene in personal habits, and bad sanitary surroundings. These factors all singly or collectively tend to lower the vitality of the whole human organism, and as a consequence the cells throughout the body perform their various functions imperfectly, or not at all. The quality of the blood becomes very much lowered, with the result that tissues that have important work to perform, do not receive sufficient nourishment and so falter from actual incapacity. The red blood cells are reduced in numbers and the hemoglobin is likewise diminished. Because of the blood poverty the digestive process is arrested, nutritive material is neither digested nor absorbed, and a general state of inanition ensues. It is not surprising under these circumstances, therefore, that chronic inflammation of the mucous membranes is produced. These highly organized structures with very important duties to perform naturally suffer from insufficient nutritional support, and the phenomena of catarrh follow as a logical result. Perversion and degeneration of the cells in turn takes place, and more or less permanent changes are produced in the identity and function of the tissues.

Appropriate treatment should consist primarily in correcting or eliminating all contributing factors of a bad hygienic or insanitary character. The individual should be placed under the most favorable conditions possible and every effort made to readjust the personal regime. Local conditions of the nose, throat, the vagina, or any other part, should be made as nearly normal as possible by suitable local applica-

tions or necessary operative procedures. Then attention should be directed immediately to improving the quality of the blood and thus increase the general vitality. For this purpose vigorous tonics and hematics are desirable and Pepto-Mangan (Gude) will be found especially useful. Through the agency of this eligible preparation, the blood is rapidly improved, the organs and tissues become properly nourished and accordingly resume their different functions. Digestion and assimilation are stimulated and restored to normal activity, and the various cells and organs start up just as would a factory after a period of idleness. In fact Pepto-Mangan (Gude) supplies the necessary elements that are needed to establish the harmonious working of the whole organism. When this result is achieved, the catarrhal condition is decreased to a minimum and distressing symptoms are banished, a consumation that is highly gratifying to every afflicted patient, and every earnest practitioner.

DERANGED UTERINE FUNCTION.

James A. Black, M. D., Morganza, Pa.

It is safe to say that to the average physician, who is confronted almost daily with the ordinary cases of suppressed and deranged uterine function, no other class of cases is so uniformly disappointing in results and yields so sparing a return for the care and time devoted to their conduct.

Patients suffering from disorders of this nature are usually drawn from the middle walk of life, and, by reason of the pressure of household duties or the performance of the daily tasks incidental to their vocation, are entirely unable, in the slightest degree, to assist, by proper rest or procedure, the action of the administered remedy.

Many of these patients, too, suffer in silence for months, and even when forced by the extremity of their sufferings to the physician, shrink from relating a complete history of their condition and absolutely refuse to submit to an examination. Authoritative medical teaching and experience unite in forcing upon the attendant a most pessimistic view of his efforts in behalf of these sufferers under such conditions.

It is in this class of practice, where almost everything depends upon the remedy alone, that a peculiarly aggravating condition of affairs exists. A very limited list of remedies of demonstrated value is present-

ed for selection, and I believe I am not wide of the mark in saying that, in the hands of most practitioners, no remedy or combination of remedies hitherto in general use has been productive of anything but disappointment.

Some time ago my attention was drawn to Ergoapiol (Smith) as a combination of value in the treatment of a great variety of uterine disorders. Its exhibition in several cases in my hands yielded such happy results that I have used it repeatedly in a considerable variety of conditions, and with such uniformly good results that I am confirmed in the opinion that its introduction to the profession marks an era in modern therapeutics. In the treatment of irregular menstruation and attendant conditions I have found it superior to any other emmenagogue with which I am familiar, in the following particulars:

1. It is prompt and certain in its action.
2. It is not nauseating and is not rejected by delicate stomachs.
3. It is absolutely innocuous.
4. It occasions no unpleasant after-effects.
5. It is convenient to dispense and administer.

The following clinical notes will afford a general idea of its action in a variety of cases:

Case 1. Mrs.—— came to me presenting the following symptoms incident to a delayed menstruation: Persistent headache of a neuralgic character; dull, aching pain in limbs and lumbar region; cramp-like pains in abdomen, and considerable nausea. The menstrual period was overdue seven days, but as yet there was no appearance of flow. Her periods had always been occasions of intense suffering, but had never before been delayed. I began the use of Ergoapiol (Smith), with some misgiving owing to the irritable condition of the stomach. One capsule every three hours was administered without any aggravation of the gastric distress. In twenty hours a normal menstruation was well under way; the flow was slightly increased over the observed on former occasions. The pains had subsided. Ergoapiol (Smith) was administered, one capsule three times a day, during the menstrual period, which terminated in five days. The patient was instructed to return for a quantity of the remedy several days before the next menstrual period. She did so, and following directions, took one capsule three

times a day for three days before expected menstruation. She subsequently reported that during the period—lasting five days—there had been practically no pain, and the amount of flow was, as far as she could judge, normal.

Case 2. Miss ———, aged thirty, has been a sufferer for years with dysmenorrhoea. For about three years had suffered with leucorrhoea, particularly annoying after each menstrual period. Had undergone treatment at different times for the leucorrhoea and dysmenorrhoea, but had never experienced permanent benefit. She had been obliged to spend the couple of days of each period in bed. She consulted me about one week before her period. Examination revealed a purulent discharge oozing from os cervix and a rather large uterus. There was no displacement. She was put upon Ergoapiol (Smith), one capsule three times a day. The onset occurred one day earlier than expected and was attended with considerable pain. The patient was, however, able to attend to her usual duties, a state of affairs such as had not been experienced for some years. At the onset of the flow Ergoapiol (Smith) was administered, one capsule every two hours. The effect was astonishing. In eight hours the pains had well-nigh subsided and there was practically no discomfort, except some pain in back.

Case 3. Miss ———, aged twenty-one, had suffered for two years with irregular and painful menstruation. Had commenced to menstruate when sixteen, menses being very scanty, but regular and accompanied with but slight degree of suffering. Was never of a very robust physique, but in the main healthy. When about nineteen, considerable nervous trouble was inaugurated by grieving over a great bereavement, and the menses became more and more painful. The anguish became such a horror to her that she frequently resorted to morphine, partly to allay pain and partly to procure sleep. Fortunately she had not, as yet, contracted the habit, but the tendency was undoubtedly in that direction. When first consulted by her, examination was not granted. Menses appearing shortly afterward, was called upon to afford relief. Flow was very scanty and clotted. There were sleeplessness, terrific headache, pain in back, constipation, etc. Ergoapiol (Smith) was administered, one capsule every three hours. Flow was considerably increased, there was a gradual lessening of all the suffering, and almost complete relief in twelve hours. This young wo-

man has been placed upon Ergoapiol (Smith), one capsule twice daily for one week preceding appearance of menses, and has passed through several periods with very little suffering. An examination made recently showed a marked retroversion and very sensitive cervix. A properly applied supporter will doubtless work considerable benefit in her case, but it can not be disputed that the comparatively easy menstruations occurring recently, in spite of the displacement, were due entirely to Ergoapiol.

Case 4. Miss ———, aged eighteen, had always been regular in menstruating. Could get no history of any previous disorder within patient's knowledge. Contracted a heavy cold about time of menstrual epoch, and was much alarmed by non-appearance of flow. Discomfort was not marked. Ergoapiol (Smith) one capsule three times a day was prescribed. Reported later that flow was established in twenty-four hours after treatment was commenced. The delay in this case was about four days. •

Case 5. Mrs. ——— consulted me, giving the following history: Three months previously had had a profuse uterine hemorrhage occurring about the time of menstrual period. As she had for a number of years menstruated only at intervals of about six or seven weeks, the fact that menstruation has been suspended for six weeks before the date of trouble was not especially significant. The hemorrhage, which was at no time alarming, had continued for several days. Since that time there had been an almost constant wasting and at times a considerable flow. Her condition was practically invalid. Examination revealed a gaping os, a cervix exceedingly tender and abraded, and a large uterus. Before resorting to currettement it seemed advisable to try other measures. Ergoapiol (Smith) one capsule every three hours, was prescribed. In about twenty-four hours there was a decided increase in the discharge, which consisted of clots and considerable debris. There were some pains of a cramp-like nature. The discharge began to grow less in about four days and ceased entirely in one week. There was a marked improvement in general condition. Local treatment entirely removed the tenderness and abraded condition of cervix. Ergoapiol (Smith) was administered several days before next menstrual period and resulted in a very satisfactory period. In this case it appears

to me the remedy saved the patient the ordeal of curettement, acting as a prompt uterine stimulant. Her condition locally and generally has since steadily improved.

DR. EDWARD C. REGISTER'S NEW BOOK.

"Practical Fever Nursing" will soon be issued from the presses of W. B. Saunders Co. of Philadelphia. Dr. Register is well known as the editor of the Charlotte Medical Journal, and as Professor of the Practice of Medicine in the North Carolina Medical College at Charlotte, N. C. Dr. Register is a widely traveled, well read and a polished, dignified gentleman. He has always enjoyed a large and lucrative practice in his home city as well as in near-by towns in adjoining states. From his varied and ripe experience in the profession the Doctor is in a position to write authoritatively on the subject of "Fever Nursing."—Gaillard's Southern Medicine.

AN ANNUAL VISITOR.

We have just passed through our annual epidemic of la grippe, which as usual, claimed its victims among all classes and conditions, mainly, however, among the classes where the resisting power was below par, or among sufferers from some chronic ailment. While the sequelae and complications of this disease may assume almost any phase of acute inflammatory character, its primary effect is upon the nervous system. Therefore, we have no hesitancy in saying, no matter what the local inflammation may require as a medicine, by all means give antikamnia tablets as a nerve sedative and to relieve the muscular pains always present. We have seen a violent cough of bronchitis treated upon the general plan, with the cough as distressing at the end of twenty-four hours as at the beginning, promptly yield to six antikamnia tablets during an interval of six hours. La grippe usually requires a double treatment, one directed to the influenza, and the other devoted to the complications present, be they of the respiratory organs or digestive tract. In all cases antikamnia tablets will be found to perform a prominent and successful part and purpose.—Medical Reprints.

Miscellaneous Notes.

"ERGOAPIOL" (SMITH): ITS THERAPEUTICAL INDICATIONS: WITH CLINICAL NOTES.

By C. W. Canan, B. S., M. D., Ph. D.

We desire to call the attention of the medical profession to a new pharmaceutical product possessing valuable therapeutic virtues in many diseases peculiar to women. This remedy is known as "Ergoapiol" (Smith), and since its introduction to the profession it has rapidly gained favor with our best physicians. It is strictly ethical, manufactured from the purest drugs and advertised only to physicians.

It is the result of an original combination of the following remedies: apiol, ergotin, oil of savin, and aloin, all of which are freed from toxic and deleterious substances. These agents are blended in such proportions as to overcome the powerful irritating qualities of each and raise the tonic properties of all. A glance at the therapeutical indications of these remedies singly will convince the most sceptical of the virtues of "Ergoapiol"—the result of their combination.

Since the days of Jaret, Homolle and Baillot, apiol has gradually grown in favor as a therapeutical agent, but until recently it had one decided drawback, that of containing deleterious and toxic impurities in combination. Recently, through the skill of the never-tiring pharmacist, these have been eliminated, and it can now be prescribed without fear of producing disagreeable symptoms, but with an assurance that its full therapeutical virtue will be realized. Even in its impure state apiol gained considerable reputation in the treatment of nephritis, dropsical effusions, amenorrhoea and dysmenorrhoea. Its emmenagogue properties have been greatly enhanced by the removal of all impurities. In small doses it now became a mild aromatic stomach tonic; it is also highly recommended in membranous dysmenorrhoea. The therapeutical value of ergotin is too well known to call forth comment here. Combined as it is in "Ergoapiol," it becomes an excellent adjunct to apiol, and adds very materially to the efficiency of the finished product.

All students of medicine are aware that oil of savin is a powerful and valuable stimulant to the uterine system, and is one of the most potent emmenagogues known. It is also a powerful gastro-intestinal

irritant, and therefore is seldom prescribed alone. But when combined with certain correctives, as it is in "Ergoapiol," it becomes a valuable addition to the drugs already named—apiol and ergotin.

Since the discovery of the methods of producing aloin from the different brands of aloes this drug has become very popular, and has taken the place of the crude drug to a considerable degree. Aloin enters into almost every emmenagogue pill and mixture. Its value as a therapeutical agent is so well known that it is not necessary for us to speak of it in detail; yet we desire to say that its addition to the drugs in question aids very materially in making "Ergoapiol," so valuable a combination. Being a mild stomach tonic, it aids in overcoming the irritable qualities of the savin; also acting as a hepatic stimulant, freeing the portal circulation and relieving the torpid condition of the lower bowel, it goes a great way toward relieving that condition so often present in diseases of women—pelvic engorgement. These qualities make it an ideal adjunct to the emmenagogues mentioned.

Our attention was called to "Ergoapiol" (Smith) through a reprint from a St. Louis journal. This reprint gave the names of remedies entering into the combination. We at once concluded that this product would be a useful one, and securing a supply we began prescribing it whenever indicated.

The results were even greater than we had anticipated. From the beginning we have kept clinical notes of each case, some of which will be recorded in this article. "Ergoapiol" is a mild, aromatic stomach tonic, anodyne, antispasmodic, and hepatic stimulant. It is also a laxative, an ideal emmenagogue in the full sense of the term, and exerts a decided tonic influence upon atonic conditions of the pelvic viscera. It is indicated to a greater or less extent in all forms of dysmenorrhoea, viz., atonic, congestive, obstructive and membranous. In true obstructive dysmenorrhoea due to actual stenosis of the uterine canal, to a sharp flexure of the organ, or to the valve-like action of a clot or a polyp it is seldom indicated because this form of organic dysmenorrhoea requires either surgical operations or mechanical means to effect a cure. However, good results may be expected from its use after such operations have failed to complete a cure or to relieve the suffering. It is even useful in the form where clots cause the trouble by

their mechanical obstruction, and we have seen its administration cause the passage of a polyp in one patient. Good results may be expected from its use in that form of dysmenorrhoea known as membranous, due to an exfoliation of the endometrium in the form of a membrane. In amenorrhoea it is far superior in value to any remedy we have yet tried, if the cases are properly selected. Amenorrhoea due to taking cold at the menstrual period, or caused by shock, can be relieved with the remedy in question.

This remedy is occasionally beneficial in certain forms of metrorrhagia, after operations to remove fungoid or polypoid growths, or after curetting the uterus. It is a remedy of great value in menorrhagia, especially in that form due to faecal impaction, with torpidity of the liver in persons nearing the menopause. Where this trouble occurs in a plethoric and indolent subject the following plan of treatment will generally be all that is necessary: Begin three or four days before menstruation is due and give one brisk mercurial purge, then follow with *Ergoapiol*," one capsule three times per day. If this plan is carried out for several months at each menstrual period, a cure will be the result.

"*Ergoapiol*" is especially indicated when disturbances of menstruation occur in feeble and anaemic women. It should be alternated with some form of iron in such cases.

There is a condition in which the patient's menses are regular as far as time is concerned, but the flow is very scant, exceedingly thick, tarry in color, with an offensive odor. The patient suffers pain and weight in the pelvis and back; is despondent, loses flesh and strength, and may or may not suffer from various reflex disturbances. In this state of affairs "*Ergoapiol*" will be found a sheet anchor.

Before recording the clinical notes gathered while prescribing the drug under consideration, we wish to call attention to one or two important things before leaving the subject. The first is that form of amenorrhoea that is brought about by constitutional disease, such as tuberculosis. In these conditions it is a common occurrence to have women insist on their physicians giving them something to bring on menstruation, thinking that its absence is the cause of their condition, when the fact is, the stopping of menses is only a wise provision of nature to prevent faster decline of vital forces. The course to be pursued is to treat the constitutional disease, and when a cure of the latter has been accomplished, this form of amenorrhoea will generally take care

of itself. However, when the patient's general health has been restored and the function fails to return, then "Ergoapiol" can be prescribed with good results. Our second subject is that of prescribing emmenagogues indiscriminately without regard to the cause of amenorrhoea. Women who know or suspect themselves to be pregnant, frequently consult a physician in the hope that, in the attempt to bring on menstruation, he will really succeed in causing abortion. Whoever, under such circumstances, prescribes "Ergoapiol" with the understood purpose of inducing the menstrual flow, is liable to have criminal charges brought against him in case abortion actually does take place, even as the result of something the woman has taken or done herself. Before prescribing "Ergoapiol" in amenorrhoea the physician should satisfy himself that pregnancy does not exist, and in case of doubt he should decline the management of the case, unless he can protect himself by securing some trustworthy consultant who will share the responsibility of the case.

THE VALUE OF THE PURE FOOD LAW.

The New Pure Food Law enacted by Congress last June is one of the most far reaching and beneficial provisions ever inserted in the statute books of our country, and its effect will be felt by every class and condition of the people.

It is gratifying to know that when the government, for the purpose of insuring purity by forbidding adulteration, says that a product must be exactly what its label represents, that you are not forced to make hurried changes in formula or label, but that the goods of your manufacture have always been conscientiously prepared and advertised—that the crime of misbranding has been left for others to commit.

Daniel's Conct. Tinct. Passiflora is derived by a process that has been in use for 50 years, from the cultivated may-pop, the fruit of the greatest sedative value known to medicine, and as nearly every practitioner in the United States will testify, appeals directly to the nerve-centres, allays irritation, restores neural equilibrium and eradicates every disease due to a disordered nervous system.

Since the enactment of the Pure Food Law, the so-called passiflora tablets and other spurious preparations purporting to be made from the may-pop have been withdrawn from the market, while the medical profession, recognizing the genuineness of Daniel's Passiflora is employing it far more extensively than ever before.